



The Royal Australian
College of General
Practitioners

RACGP Submission to the Senate Community Affairs Reference Committee

*Inquiry into Commonwealth funding and
administration of mental health services*

1 August 2011

1. Introduction

The Royal Australian College of General Practitioners (RACGP) thanks the Senate Community Affairs Committee for the opportunity to contribute to discussions regarding Commonwealth funding and administration of mental health services.

The RACGP is the specialty medical college for general practice in Australia, responsible for defining the nature of the discipline, setting the standards and curriculum for education and training, maintaining the standards for quality clinical practice, and supporting general practitioners in their pursuit of excellence in patient care and community service.

This submission is made in response to the inquiry announced on the 23 June 2011, into Commonwealth funding and administration of mental health services in Australia.

Details of the Senate Committee's inquiry can be found at:

http://www.aph.gov.au/senate/committee/clac_ctte/comm_fund_men_hlth/index.htm

2. Executive Summary

The College is gravely concerned regarding the proposed cuts to the Better Access program and the subsequent impact on mental health delivery for every patient age group, demographic, and geography throughout Australia.

The cuts to the Better Access program announced in the 2011-2012 Federal Budget will affect an estimated 1 million patients per annum, risking the current high patient access levels, quality of patient care, and the mental health workforce capacity.

General practice is the linchpin for high quality mental healthcare delivery in every state and territory throughout Australia. General practice provides whole patient, coordinated, ongoing healthcare for people with mental health conditions as diverse as depression, social phobia, bereavement, postnatal depression, anxiety disorder, sleep disturbance, and bipolar disorder.

As of June 2011, 12,176 general practitioners hold Fellowship with the RACGP (representing 65% of RACGP members), and have demonstrated skills in mental healthcare ranging from patient counselling to psychosis management. As of May 2011, 17,392 general practitioners have further demonstrated their commitment to high quality mental healthcare through General Practice Mental Health Standards Collaboration training activities as part of the Better Access program.

The Budget cuts have been proposed despite the proven benefits of the Better Access program, including improved patient access to mental health services (rising from 37% in 2006 to 46% in 2009) and improved mental health outcomes. The Budget cuts will decimate the delivery of mental healthcare in Australia, and ultimately make the Better Access program unfeasible.

The RACGP advises that the Bettering the Evaluation and Care of Health (BEACH) data, used to justify the cuts to patient rebates, only took into consideration the face-to-face clinical time spent preparing the mental health plans, and did not include the additional non-clinical time spent preparing the mental health plans, and coordinating patient care outside of the patient consultation.

A recent survey shows that general practitioners are spending 17 minutes on average preparing mental health plans outside of the patient consultation (in addition to the 28 minutes of clinical time shown in the BEACH data), which means that general practitioners are spending a total of 45 minutes on average preparing mental health plans.

Another significant concern regarding the recently announced cuts is that patient rebates for mental healthcare will be lower than patient rebates for physical healthcare, suggesting that mental health is not as important as physical health.

The RACGP also notes that we were neither consulted, nor even properly advised, of the cuts to the Better Access initiative prior to the 2011-2012 Budget announcement.

General practice plays a crucial role in the delivery of early intervention and prevention mental health services, as well as holistic, whole patient care, for both physical and mental health. As such, general practice must be supported to ensure ongoing, high quality access to mental health services in Australia.

The College recommends an immediate suspension of the proposed cuts to the Better Access program, and calls on the Government to conduct a comprehensive review, including consultation with the profession, consumer groups, and all other stakeholders, to identify a revised approach which does not reduce access to high quality mental healthcare support for Australians.

3. RACGP response to the Senate inquiry

In the context of the Commonwealth funding and administration of mental health services Inquiry, the RACGP submission responds to the following issues identified by the Inquiry:

1. The changes to the Better Access Initiative, including:
 - the rationalisation of general practitioner mental health services
 - the impact of changes to the Medicare rebates and the and the two-tiered rebate structure for clinical assessment and preparation of a care plan by GPs.
2. Services available for people with severe mental illness and the coordination of those services
3. Mental health workforce
4. The adequacy of mental health funding and services for disadvantaged groups, including:
 - culturally and linguistically diverse communities
 - indigenous communities
 - people with disabilities
 - the impact of on-line services for people with mental illness, with particular regard to those living in rural and remote locations and other hard to reach groups, and any other related matter.

3.1 Changes to the Better Access Initiative

3.1.1 Changes to Better Access

In 2006, the Better Access program was introduced to improve treatment and management of mental illness within the community through team-based mental health care, with general practitioners working collaboratively with psychiatrists, clinical or registered psychologists, social workers, and occupational therapists.

Since its introduction, there has been a steady increase in the number of people treated for mental illnesses each year, with service coverage climbing from 37.4% in 2007 to 46.1% in 2009.¹ Patients accessing these services have experienced positive mental health outcomes, particularly for those with the worst baseline psychological distress.²

Despite the benefits, the 2011-12 Federal Budget dramatically reduced GP mental health service funding by \$405.8 million over five years.

This reflects a reduction in the monetary value of patient rebates for MBS Items 2702, 2710, 2712, and 2713, which were first made available to patients in 2006 as part of the Better Access Initiative. Table 3 overleaf sets out the proposed time-tiered reduction in patient rebates.

Table 3: Changes to MBS Patient Rebates for GP Mental Health Services

		Previous policy	New policy		
MBS Items for services provided by GPs with additional mental health skills training					
MBS item		MBS fee 1/11/10	New time tier	Proposed new fee	% cut in fee
2710	GPMHTP	\$163.55	<40 mins	\$85.00	-48.0%
2710	GPMHTP	\$163.55	40+ mins	\$126.00	-23.0%
2712	GPMHTPR	\$108.90	NA	\$67.67	-37.9%
2713	GPMHTPC	\$71.85	NA	\$67.67	-5.8%
MBS Items for services provided by GPs without additional mental health skills training					
2702	GPMHTP	\$128.20	<40 mins	\$67.65	-47.2%
2702	GPMHTP	\$128.20	40+ mins	\$99.55	-22.3%

GPMHTP – GP Mental Health Treatment Plan; GPMHTPR – GP Mental Health Treatment Plan Review; GPMHTPC –GP Mental Health Treatment Plan Consultation.

As shown above, the percentage reduction in patient rebates ranges from 48.0% for the GP Mental Health Treatment Plans (MBS Item 2710) to 5.8% for the GP Mental Health Treatment Plan Consultations (MBS Item 2713).

The BEACH data used to justify the reductions to patient rebates only took into consideration the face-to-face clinical time spent preparing the mental health plans, and did not include the additional non-clinical time spent preparing and coordinating patient's care outside of the patient consultation.

A recent survey, conducted by the Australian Medical Association, shows that general practitioners are spending 17 minutes on average preparing mental health plans outside of the patient consultation – in addition to the 28 minutes of clinical time.³ Therefore, general practitioners are spending an average of 45 minutes in total preparing mental health plans.

Similarly, the survey also shows that general practitioners are spending an additional 13 minutes outside of the patient consultation for GP Mental Health Treatment Plan Reviews and GP Mental Health Treatment Plan Consultations (MBS items 2712 and 2713) in addition to the face-to-face clinical time.⁴

Ultimately, the reduced patient rebates fail to recognise:

- time spent coordinating patient care, preparing mental health plans, and conducting reviews outside of the patient consultation
- the complexity of the mental health treatment plan and coordination activities
- additional patient follow-up strategies
- bulk-billed consultations once the patient is engaged.

3.1.2 Consequences of the changes to Better Access

The changes to the GP mental health service patient rebate (particularly MBS Item 2710) will make it difficult, if not impossible, for general practitioners to continue bulk-billing for mental health services, which in the final year (2009) of the Better Access Initiative Evaluation, stood at 92.7% of GP mental health services provided.⁵

These changes will inevitably force general practitioners to either:

- charge a patient co-payment, which will compromise access for many vulnerable groups

- reduce the quality of the mental health services, as some general practitioners may be forced to compromise the comprehensive care they are currently providing in order to remain financially viable service providers
- disengage from the Better Access program altogether, reducing access to mental health services, especially for patients in urban, rural, and remote areas of need, who may not have any access to another mental health professional.

As a result, we are likely to see a drop in service use due to economic access barriers, plus a reduction in quality of the remaining services. There is also a significant risk that service coverage will drop due to general practitioners withdrawing from the Better Access program as a result of unsustainably.

All of these outcomes are undesirable.

3.1.3 Health care coordination – mental and physical illness

Regardless of whether health care coordination is for psychiatric or physical illness, effective general practice coordination includes:

- discussion of a patient's history
- identification of the patient's multidisciplinary care needs
- identification of outcomes to be achieved
- identification of tasks that need to be undertaken to achieve these outcomes
- allocation of specific tasks to appropriate members of the health care team
- assessment of whether previously identified outcomes (if any) have been achieved.

For physical conditions present for at least 6 months, the patient rebate for developing a General Practice Management Plan is \$136.05.

This is higher than the revised GP Mental Health Treatment Plan rebate (which will be \$85 for less than 40 minutes or \$126 for more than 40 minutes), suggesting that the coordination of patient care for physical illness is valued more than it is for mental illness, which can be equally if not more functionally debilitating.

3.2 Services available for people with severe mental illness and the coordination of those services

Depending on the definition used, an estimated 3% of Australian adults have severe mental illness, which represents approximately half a million Australians.⁶ About 50% have a psychotic illness, primarily schizophrenia or bipolar affective disorder. The remainder mainly comprise individuals with severe depression or severe anxiety disorders.⁷

Prior to the introduction of the Better Access program, only 34% of these patients were reportedly accessing mental health services.⁸ Where services were accessed, general practitioners were the most commonly consulted health professional group.⁹

The top three most frequently reported mental health disorders managed by general practitioners were:

- depression (accounting for 34.3% of all mental health-related problems managed)

- anxiety disorders (15.6%)
- sleep disturbance (12.6%).¹⁰

These findings are consistent with the Better Access Initiative Evaluation findings which suggested that Better Access GP mental health service users are not typically people with mild symptoms. Most have clinically diagnosable disorders, predominantly depression and/or anxiety, as well as substance abuse, with most experiencing significant levels of psychological distress.¹¹

Treating mental illness in general practice often involves a bio-psycho-social understanding of the aetiology of mental illness and a patient centred approach, combined with a holistic, comprehensive, continuous, multidisciplinary team effort to achieve the best patient outcomes.

In providing services for patients with severe mental illness, general practitioners typically:

- perform a behavioural, emotional and cognitive assessment within the context of a patient's physical health needs – including background chronic and current acute problems – with knowledge of their current personal and social circumstances and past experiences
- differentiate normal reactions to life stresses from overt mental illness
- decide on the appropriate course of action, which often involves development of the appropriate treatment strategies in consultation with other members of a patient's mental health care team (including the patient and informal carers)
- coordinate the necessary clinical activities and resources, across different clinical settings, over an extended period of time.

Hence general practitioners are a critical access point for patients with severe mental illness, and comprise a significant part of the mental health workforce. A reduction in patient rebates for mental health services provided by general practitioners, through the Better Access program, will potentially result in lower levels of access for people with a severe mental illness.

3.3 Mental health workforce

The provision of effective mental health services is dependent on the availability of a range of skilled mental health professionals, including:

- General practitioners
- Psychiatrists
- Mental health nurses
- Psychologists
- Occupational therapists
- Social workers.

General practitioners are a vital, sizeable and well equipped component of the Australian mental health workforce that needs to be properly recognised for the contribution they make to treatment or management of mental illnesses in Australia.

Given general practitioners' high level of involvement in mental health service provision, the RACGP has incorporated mental health learning requirements in the Fellowship Training Program Curriculum.

Upon completion of the RACGP Fellowship Training Program, graduating general practitioners must be able to demonstrate:

- skills for mental health assessment, including an ability to:
 - understand the epidemiology and aetiology of common mental health conditions and complexities of co-morbidity
 - effectively apply skills in psychiatric history taking, mental status assessment and risk assessment in the general practice setting
 - detect and differentiate the common mental health disorders in general practice
 - demonstrate appropriate use of psychometric instruments to aid assessment
 - demonstrate how to differentiate a patient's reaction to normal life stresses from overt mental illness
 - include mental health assessment in undifferentiated clinical presentations
 - assess the functional impact of mental health disorders on a patient.
- skills for mental health care planning, including an ability to:
 - negotiate a mental health plan with patients, carers and health professionals considering patient and carer preferences, concerns and resources
 - communicate the evidence basis for common treatments to patients and carers
 - describe appropriate patient and carer education methods and materials
 - describe local mental health care providers and systems including non-government organisations, eg. self help groups
 - describe available pharmacological and psychological therapies and utilise these therapies in an evidence based way
 - outline the principles of detoxification and withdrawal.
- skills for mental health care delivery, including an ability to:
 - deliver focused psychological strategies as defined by the Better Outcomes in Mental Health Initiative
 - competently prescribe psychoactive medication with an evidence based approach
 - work collaboratively with members of the local health care network
- skill for mental health ongoing review, including an ability to:
 - describe the need for systematic monitoring of the effectiveness of a mental health plan
 - manage comorbidity of mental and physical illness
 - engage patients in self monitoring to identify recurrence
 - assist patients and carers to develop a personal relapse prevention plan.¹²

Following attainment of Fellowship, the RACGP gives general practitioners further opportunity to maintain and enhance their mental health service skills through the Quality Improvement and Continuing Professional Development program¹³ and the General Practice Mental Health Standards Collaboration (GPMHSC).¹⁴

The GPMHSC is a multidisciplinary body auspiced by the RACGP and funded by the Australian Government, as part of the Better Outcomes in Mental Health Care program, that is responsible for:

- establishing standards of education and training in mental health care under the Better Access program

- promoting the development and uptake of quality professional development activities in mental health care for general practitioners.

The GPMHSC approved training activities include the:

- Better Access program mental health skills training activities – which provide participants with skills in recognising and assessing mental disorders, preparing mental health treatment plans grounded in evidence based practice and the ongoing monitoring and review of progress
- Focussed Psychological Skills (FPS) training activities – which provide participants with skills in specific mental health treatment strategies, derived from evidence based psychological therapies. General practitioners with this qualification are eligible for the higher patient rebates (MBS item numbers 2710, 2712 and 2713).
- Focussed Psychological Strategies continuing professional development training activities – which consolidate and extend general practitioners' skills in the provision of FPS as part of treatment plans for mental health problems.¹⁵

These multidisciplinary training programs bring different professional groups together in a shared learning environment, reflecting the team based nature of primary care with the potential to improve collaboration between different service providers.

Since introduction of the GPMHSC training activities, 17,392 general practitioners as of May 2011 have undertaken extended skills training in mental health, making their patients eligible for the higher MBS patient rebates associated with MBS items 2710, 2712, and 2713.¹⁶

3.4 The adequacy of mental health funding and services for disadvantaged groups

According to the Better Access program evaluation report, it appears that disadvantaged groups are still being under-served despite the moderate growth in GP mental health service uptake.

However, the extent of their disadvantage is largely unknown as the Better Access program evaluation was not able to assess this question for all groups who are traditionally disadvantaged in their access to mental healthcare. No data were available for some groups, particularly people from culturally and linguistically diverse backgrounds, and Aboriginal and Torres Strait Islander people.

Notwithstanding the above, it is important to note that the most dramatic increase in rate of uptake was in groups disadvantaged in the past.

Hence, diverting funding from universally accessible mental health care provided by general practitioners, as part of routine clinical practice, to programs based on limited international evidence, aimed at limited patient groups, with limited reach, is likely to reduce mental health service coverage, and reduce patient access to mental health services.

4. Concluding comments and recommendations

The RACGP is gravely concerned regarding the cuts to the Better Access program and the resulting impact on the quality and delivery of Australian mental healthcare services across all patient demographic groups and geographical locations in all Australian states and territories.

The recent changes to mental health funding announced in the 2011-2012 Budget were prepared with input from a small group of stakeholders, who may not represent the broad views of stakeholders more widely.

Whilst the RACGP recognises the need to continually assess and improve the quality and delivery of mental health services, this initiative has the potential to damage the high standards of healthcare that many Australians currently enjoy.

Further, diverting funding from universally accessible mental health delivery to programs based on limited international evidence, aimed at limited patient groups, with limited reach, is likely to reduce patients' access to comprehensive mental healthcare planning and support.

The College does not wish to see the excellent gains made in mental healthcare delivery over the past few years – achieved predominantly through the Better Access program – compromised.

Mental health services remain underfunded, and mental healthcare deserves a greater focus and its rightful share of total health funding. Integrating mental health services into primary care is the most viable way of closing the treatment gap and ensuring that people get the mental healthcare they need.¹⁷

The RACGP therefore recommends:

1. An immediate suspension of the proposed funding cuts to the Better Access program
2. That the Government conducts a comprehensive review, including consultation with the profession, consumer groups, and all other stakeholders, to identify a revised approach which does not reduce access to high quality mental healthcare support for Australians across all states and territories
3. That the revised approach preserves high quality prevention and early intervention, and does not reduce access to these critical care elements.

5. General practitioner stories and comments regarding funding cuts to mental health services

On 22 July 2011, the RACGP invited GPs to comment on the Government's changes to the Better Access Initiative through the RACGP's weekly *FridayFacts* publication. The vast majority of GPs expressed significant concern regarding the likely impact of the Government's funding cuts on patient services.

The following stories and comments received illustrate the nature of their concerns:

- I am a GP in [de-identified rural Queensland town] of some 14,000 people and probably another 5000 in the surrounding district. The farmers and graziers of the district have recently suffered 10 years of drought, followed by 6 weeks of devastating floods as well as the uncertainty associated with the coal gasification and mining prime farm land. Mental health issues are a large component of my workload and with the natural disasters and external threats it will continue for considerable time.

The members of my community fall into the groups that Better Access evaluation identified as missing out on services under the current system including 2710

- Men
- Rural and region communities
- People under 25 years
- Lower socioeconomic groups

Altering the rebate for item 2710 /changing the way the item is rebated under Medicare will further limit access of these groups in my community because the doctors in the practice will be forced to charge an out of pocket gap in order to maintain our viability. Currently for preparation of a mental health care plan my Practice is to bulk bill - and the plan can take up to 40 minutes for me to complete however with the changes it will not be viable to continue to bulk bill my patients and many of them are not in a financial position to be able to pay the gap. Thus limiting access

My community like other rural and remote communities will not be able to support "headspace" centre so we will miss out in all areas

Many patients have difficulty accessing GP services due to lack of GPs. A considerable proportion of my workload is mental health and we know from BEACH data that female GPs spend longer in consultations and are more likely to see patients with psychological and mental health issues. Access to psychologists is limited in my town with 2 private psychologists and the others are 86 km away so much of the mental health treatment falls to the GPs.

The state health department has wound back much of the public psychiatric services with a 6 week wait for urgent consultations with a psychiatrist and the majority of these are by video link (and we are only an hour by road). Much of the public mental health service is undertaken by mental health trained nurses, social workers and OT who case conference weekly with a psychiatrist and the patient may not even see the psychiatrist.

ATAPS has been greatly restricted by our division and difficult to access and my colleagues have expressed similar experiences. With the proposal to

increase funding for ATAPS and have it administered by Medicare Locals rural GPs see this as a hit to the mental health service on all sides. Shortly there will be 15 Medicare locals that are unlikely to serve our rural communities well particularly when there is no clarity about what they will look like. Access to ATAPS still requires preparation of a mental health care plan. A similar picture is repeated across the country where there is a GP shortage / psychiatrist shortage which will limit access to the mental health services whether it is Better Access or ATAPS

- I am a GP who services a group of intellectually disabled adults many of whom have a dual diagnosis that includes mental illness. This large group of over 200 patients depends solely on the advocacy of me as their GP to facilitate access to other mental health professionals. The area health has continuously let them down. These Mental Health Item numbers are vital to my work with this very vulnerable group that is neglected by the hospitals and community mental health units. Reducing or changing the rebate for these items will directly affect this and other patients with intellectual disability access to proper care.
- I am a GP in [de-identified eastern Perth suburb], Western Australia. I am very concerned about the impact the imminent mental health funding cuts will have on the patients in my area. I implore those who have the power to do so, to reverse this decision.

A very large proportion of my patients with mental health issues are unemployed, on disability pensions, students, or aged pensioners. The cost of private psychological treatments is ridiculously prohibitive. There is a public service nearby, but as the demand is so great they can only take patients who have had to be admitted to hospital for their mental illnesses. Occasionally there are a few low-cost services available but these are staffed by students who are not yet fully qualified.

Mental health is a much larger issue than it may seem. An individual who is mentally ill has a wide impact on the rest of society- they will be less productive at work; they will draw more on social services and pay less tax; they drain the time, energy and money of their carers, friends and families; and they will raise children who are more likely to go on and have mental illnesses themselves.

Please take this opportunity to make a positive change in the lives of countless men, women and children.

- I'm probably not different from most GP's who see an increasing burden of mental ill health in their day to day work. The effort that goes into preparing a mental health plan for these people is every bit as challenging (and time consuming) as the preparation of a Management Plan for physical ill health. Most people I see need a minimum of 6 visits with a psychologist, with many needing far more than that. Patients time their visits to me with those to the psychologist to make sure that they will get the rebate – without it, they would not be able to see a psychologist (and, although I do have further training in focussed psychological strategies, I cannot spend as much time with each patient as that really requires to be done properly). The coming changes, should they be approved, would result in the following:

1. I would be less keen to do the MHP, knowing that the effort going in to preparing this would not be rewarded financially. I have recently started up my own practice, and am very aware of the financial situation in terms of money made for time spent that will make my practice viable (or not).
2. Should I have the time to prepare the MHP, the patient would not be able to access the number of visits likely to make a difference to their mental health.

Having suffered depression myself, and having a foster child recovering from severe trauma, we both make the most of the Mental Health Plan in its current form. While I can afford to pay for some sessions out of my own pocket, the Child Protection Service is unable to pay for the services my child needs, should the number of sessions available to him be reduced.

I would ask that these changes be reversed. We all know the burden of mental ill health is increasing, and these proposed changes will do nothing to stem that tide.

- I am a GP in an outer metropolitan practice who sees a large number of patients with mental health problems. I am often the first port of call for suicidal patients and can prevent them from attending and clogging the emergency department of the local hospital [de-identified Perth hospital], and when a referral must be made I work closely with the patient on discharge to limit the impact on hospital resources. These patients typically take around 40minutes to see, they require regular follow up appointments which also take 30-40minutes and many are unable to pay a gap fee due to their personal circumstances, hence without the initial payment from the Mental Health Care Plan it would become unviable financially for me to continue to see them regularly, monitoring their progress and not charge gap fees. I have seen many times over that regular monitoring and psychological therapy with a supportive GP results in fewer hospital attendances, fewer hospital admissions, the patient is able to return to work sooner, and put less strain on their families who may otherwise go on to develop mental health problems. The changes to the number of psychological sessions available would impact a number of patients I have that require regular psychological therapy to again prevent further burden on more expensive and over-stretched resources such as the local mental health team and the inpatient mental health service at Joondalup.
- Currently I bulk-bill mental health services for my patients as the rebates are adequate for the time and expertise spent on the care of patients with mental illness. If the rebates are reduced as currently proposed then I will no longer be able to afford to bulk-bill these consults/plans and I will not be able to afford to follow up patients with mental illness as closely as would be clinically ideal. Financial issues are a big problem for patients with mental illness and the cost constraints imposed by the change in item numbers will limit access to mental health services for the lower socioeconomic patients who are often the ones in most need.
- I am a conscientious GP who struggles with the best care of a HUGE component of general 'everyday' patients suffering with anxiety-depression. This is an enormous work-load to correctly identify the issues, educate and reassure the patients of the diagnosis and best management plan and refer them on to an appropriate counsellor for Cognitive Behavioural Therapy (most

patients who require the full 12-18 sessions per year to benefit. this is a service, however that I perform as it is a huge problem in General practice, and the majority of my patients will benefit from this management and be able to maintain their place in their working and family roles. If funding for both the enormous time output to be able to provide this care for my MANY patients in this situation is withdrawn (and the number of counselling sessions is cut) then a huge percentage of patients will suffer as I could not continue to provide that level of care and commitment. It would encourage most GPs to either simply prescribe medications to 'fix' the problem rather than commit to the huge outlay of time that patients wouldn't / couldn't cover privately for best care or refer them back to expensive Psychiatrists to manage, or simply ignore the issues and as a GP not provide the care they need but we can't afford to give. I know many GPs are already considering 'closing their books' now to mental health care as it will become too time-consuming versus all other levels of GP care, which is only going to leave most patients suffering in silence and confusion.

- I personally do a lot of GP mental health plans every week. Such plans take a lot of time and effort in eliciting a good history and assessment of the patient, and I take time during the mental health plan to provide cognitive behavioural therapy and relevant advice as well. My plans may take up to 50 minutes to complete. Such a process is far beyond the scope of a normal consultation. If the financial incentive of the GP Mental Health Plans are cut, I would be unable to provide the same standard of service to my mental health patients, and would prefer to use the time for seeing other types of cases which are not as labour-intensive. My cessation of performing mental health plans, of course, would mean subsequently my mental health patients may not even access the psychologists' rebate. I believe that most other GPs share the same view as me. I hope the government will reconsider this cut of the GP mental health plan funding, because it would put mental health patient care into jeopardy.
- It is misguided in the extreme to reduce rebates for mental health plans as these have improved the care of a vulnerable group of patients. If some doctors were misusing this item number perhaps the descriptors needed tightening. I have increasingly adapted my practice to address the needs of the mentally ill and this is a retrograde step. Our practice also employs its own mental health nurse and I am very worried about ongoing funding for this position.
- Before we had the mental health care plans many of my patients were not able to afford or access easily a psychologist. A lot of people have probably received medication rather than counselling, which for some mental illnesses is second line. Mental health issues are time consuming and there is inadequate remuneration for such counselling. Mental health care plans go some way in bridging this gap and helping people to access a psychologist. Many of my patients will suffer from the loss of the mental health care plans, as I will not have sufficient time to devote to a detailed history and discussion of their mental health issues [regional Queensland GP]
- The reduction in funding for GP mental health plans means that I simply will not be able to spend as much time with my mental health patients. Medicine - Like all professions and vocations - is a business - and with reducing payments there is a reduction in service - this means either that the patient

will need to pay more (and this is not possible mostly in my practice) or the practitioner will need to spend less time to equate with the remuneration.

- I am writing in favour of this lobby against the government's cut of the GP Mental health plan funding. I personally do a lot of GP mental health plans every week. Such plans take a lot of time and effort in eliciting a good history and assessment of the patient, and I take time during the mental health plan to provide cognitive behavioural therapy and relevant advice as well. My plans may take up to 50 minutes to complete. Such a process is far beyond the scope of a normal consultation.

If the financial incentive of the GP mental health plans are cut, I would be unable to provide the same standard of service to my mental health patients, and would prefer to use the time for seeing other types of cases which are not as labour-intensive. My cessation of performing mental health plans, of course, would mean subsequently my mental health patients may not even access the psychologists' rebate.

I believe that most other GPs share the same view as me. I hope the government will reconsider this cut of the GP mental health plan funding, because it would put mental health patient care into jeopardy.

- The proposed cuts will seriously affect my patients with mental health issues both financially and in maintaining quality of care. Country doctors have to have many skills due to the shortage of specialist services. I see a number of mental health clients. With the funding cuts I will have to charge a larger gap payment thus financially disadvantaging them. The option is for them to travel long distances to Melbourne & its suburbs. I hope the Senate Inquiry will have a positive outcome for the GP's who provide this service.
- I work extensively in mental health and in particularly in youth mental health, both in my own practice and with headspace. All mental health is time consuming, but youth mental health is particularly so. It goes without saying that vulnerable youth are typically financially disadvantaged and have no capacity to pay any gap fees. My initial consultations with these patients are generally at least one hour. Bulk billing these consultations was feasible under the old rebates for 2710, it will not be under the proposed scheme. This will obviously place enormous difficulties in the way of servicing this high needs group. As a GP with headspace I am aware of the enormous difficulties getting GPs to work with such services. With these changes it will become frankly impossible.

My other concern is that I work closely with psychologists in the management of these clients, and due to the complexity of their presentations many need far more than the 5 + 5 sessions being mooted. I am frankly horrified at the thought of these clients being cut off at what is often the midpoint of their therapy.

My impression was that the government was seeking to improve services to groups with high unmet need such as the young and socio-economically disadvantaged. I am very proud of the work that I have been involved in with this group over the past four years, and aghast at the way it has been threatened by the proposed cuts to the better access scheme.

I have written to the minister independently (and received no reply!). I would be more than happy to be further involved in any representations.

- I would ask the government to please, particularly in view of the hugely increased physical health burden in mental health patients (increased type 2 diabetes, obesity, dementia etc), not interfere with a system which has been working. The cost of the system is testament not to roting, but to a concerning high number of needy patients. I can certainly assure the government that no patient would choose needlessly to undergo extensive psychological sessions.
- I am a GP in Melbourne Bayside area. I have some concerns about cutting the rebates for mental health items. Mental health consultations are complex and require more time than a lot of physical medical issues. One can not stop or rush a client, when they are "pouring their heart out to you", it has taken a lot of courage and attempts for them to decide to deal with the issue to come and talk to a doctor about it. The current financial rebate takes the time we spend with these people into account and shouldn't be reduced. I know I will start to rush these consultations through, this will result in client dissatisfaction and "supermarket" medicine again, where issues are not completely dealt with.
- I have been working as a GP for over 10 years, and I estimate I average doing at least 2 Mental Health Plans per week. These are always time consuming, but the reason I continue to provide this service is that most patients would not be able to afford to see psychologists otherwise – antidepressant medication alone can not help all of these patients (& sometimes is inappropriate), but my experience is that psychology input is almost always helpful.
- We have a psychologist where I work, often we discuss the issues together and decide a further plan for clients we have both seen, all this time is not financially reimbursed. However, since the current mental health rebate is adequate, it allows me to do this. The decision makers need to remember the average GP has studied for 8 years and we too have mortgages to repay!
- I have a number of patients with eating disorders, which require intensive treatment over a minimum of 18 sessions - ten sessions will not be enough to see patients through to a sustainable recovery. Given the high morbidity and mortality, this is not justifiable. Many of these patients will spend years on disability payments without effective affordable treatment. I have always considered the mental health care plan and review items to be some recognition of the prolonged time these patients require overall. The actual plan may not take long to write out - but only because of the prolonged "crisis" and other visits the doctor has already had or will have with the patient.
- In rural NSW, [de-identified town], we have a public hospital and community mental health team which is stressed to the limit, and could not in anyway cope with the number of patients seen in general practice that require counselling services. The instigation of GP mental health plans has been a godsend to my patients who without this would be left without vital support and treatment. The majority of my patients could not afford to access private psychologists without these plans it will be devastating if they are stopped or significantly limited

- Reception staff need to spend more time on the phone with these patients, and they too help out in times of crisis. Likewise, considerable nursing staff time is required to help cope with day to day crises, as well as with ECG monitoring in eating disorder patients. Because most of my patients have mental health (particularly eating disorder) problems, one receptionist is specifically allocated to caring for my patients each day. This is a cost my employer is willing to cover - but this is in part offset by earnings from the dedicated Mental Health Care items. I am not sure that this high staff usage will continue to be tolerated if earnings from these patients are reduced.
- As an inner city, predominantly business orientated practice, we are proud to offer bulk billing services to a large number of patients with mental illness. Many of these patients could certainly not afford to pay gap fees, and will not be able to attend psychology sessions without Medicare support. As it is, some patients are able to cope only whilst their 18 sessions last. For the rest of the year, they have huge difficulties - the most severe being a patient who required prolonged hospitalisation each year after her sessions ran out.
- As a GP with an interest and 'Level 2' training in Mental Health I am greatly concerned by the plans announced by our current labour Government to cut the Mental Health Budget. As a fulltime GP working 9-10 sessions a week I find that at least 80% of GP consultations have a mental health basis whether the patient is aware of mental health component or not and that there is a great demand for Psychology services.

The Better Access to Mental Health initiative has significantly improved access to mental health services by making them more affordable and accessible for the average Australian. Prior to its introduction few people could afford the services of a private Psychologist and the wait times for community based mental health services was often at least 6 months or more. The ATAPS service through the divisions of General Practice was overburdened with bureaucracy and greatly restricted people's choice of psychologist who was nominated by an administrative person with no therapeutic experience at the division. Just as in politics only 50% of voters will agree or like you, so it is with forming a working relationship with a psychologist, on average there is a 50% chance that someone will feel comfortable with another. Not having the opportunity to choose your own psychologist greatly detracted from the ability to form a therapeutic relationship. Under the Better Access to Mental Health Scheme a patient is able to choose their own psychologist and able to change psychologists if things don't work out. This makes much more sense financially as people are not wasting money on therapy sessions that are not helping because they do not feel comfortable with the therapist.

Reduction in Mental Health funding will result in my patients not being able to afford access to treatment and will lead to poorer mental health outcomes in the community as people will not seek treatment until they are really unwell. The current scheme provides the opportunity to prevent hospital admissions, suicide, damage to the next generation due to impaired parenting, reduce substance abuse, etc etc etc by intervening earlier. Poor mental health impacts negatively on physical health and contributes to increased burden of disease in general; funding Mental Health services is vital to the general health of our communities.

An anecdote on the old APTAS scheme: I used to work in Queanbeyan, NSW, many locals would see a GP in the ACT and many ACT residents would cross the border to see a GP in NSW. There was a rule that a NSW patient could not be referred by an ACT GP through the ACT division's APTAS scheme and a NSW GP could not refer an ACT patient through the NSW division's scheme. This cross border and GP division politicking caused much confusion and distress for people who were already vulnerable. I have experienced both schemes and believe the Better Access to mental Health Scheme, properly funded, is a vastly superior scheme.

Financially I will not be affected by the changes, I privately bill and will not reduce my fees just because yet again I am devalued by our current government, I do not argue for the Better Access Scheme because I want to make more money as has been suggested by our Prime Minister and Health Minister. As for Psychiatric experts 'damming the scheme', they have their own schemes for which they are pushing for funding: less funding for the Better Access Program, more funding for theirs..... Beware expert advice. The Divisions/Medical Locals etc (ie any group of people that want to hold the purse and create a layer of expensive bureaucracy between a GP and their patients that requires massive loads of re tape and administrative time wasting) also have their own agenda and jobs to fund. GPs just was an efficient, effective way to refer patients to services they need on the day that they present requesting these services.

I can only beg that the Better Access to Mental Health Scheme is not changed, it has already achieved much, the enormous uptake only indicates the burden of mental health in our community and how needed such a program is in its current form. Please be the Politicians who actually acted to MAKE Mental Health a government priority rather than those who just gave empty promises at election time.

- The Federal Government may wish to divert patients seeking mental health services away from their GPs, but this does not reflect the reality that many patients seek mental health care from their GPs almost exclusively.
- Those who are most marginalised, at greatest risk, not formally able to access psychiatric services, due to diagnostic issues, and those most likely to "fall through the cracks", will be impacted most profoundly by these changes. Lets hope common sense prevails.
- I am very disappointed at the Government's Budget decision to cut Medicare rebates for patients who need to access vital mental health services through GPs. The Government has said it wants to make mental health a priority, but withdrawing support for patients to access GP services sends the wrong message and will make access to care less affordable. These cuts will affect patients with mental illness and their families. Improving mental health care services is a very important issue for the community and providing proper support through Medicare for people to access GP mental health services is fundamental to achieving this outcome. I urge the Government to reverse these cuts and commit to improving access to mental health services through local general practices across the country.
- The reduction in the patient rebate for having a mental health treatment plan is just plain dumb and shows a complete lack of understanding of the issues.

In my [de-identified Tasmanian rural town] the local [de-identified division of general practice] has just canned the Better Access part of their psychology services as bulk billing the attendance meant they were losing money. They have sacked at least one psychologist and other sackings are likely. They felt the population couldn't absorb a bill for attending psychologists so the service is gone. The local public psychology service was reduced when [de-identified division of general practice] took over this service and now of course we have neither. We're back to the bad old days where GPs have to fill the void and do everything. Well the enthusiasm to fill the void is low. When your waiting room is overflowing, you have politicians and opinion leaders saying nurses can do all this work and another depressed patient walks into your room you just feel like screaming. Where is the help? Where is the support? At least if you stayed back late and saw these patients for long sessions at the end of the day you were paid reasonably. Now all of a sudden the depressed patient is the same as a person who comes in for a routine check. Same fee. Same effort apparently. Well I think I might see the fit people with few problems and will encourage the depressed patient to go elsewhere. Why break a boiler for no return and more importantly no thanks. The government doesn't have a clue.

- The governments proposal to cut the GP rebates for mental health plans ignores the important role that these items have in enabling GPs to properly assess and refer the most complex and disadvantaged clients to appropriate psychological services.

I work in an inner city clinic in Melbourne [de-identified clinic] that caters specifically to persons experiencing homelessness and drug addiction. This is a highly complex client group with a very high rate of significant psychological morbidity (and indeed high rates of serious mental illness including psychosis).

Appropriate rebates for MHPs and MHP reviews enable me and my colleagues to spend a longer period of time with these clients to conduct a complete assessment, to set goals and to develop a realistic management plan. The mental health planning process is very much more than a referral; it is an opportunity to engage and motivate clients.

For our many clients commencing on opiate pharmacotherapy programs a mental health plan is a key tool; again, it assists us to set goals and to engage clients in their program in a much more meaningful way. With this group of clients we hope to achieve very significant and difficult change; we need more support, not less. Already very few GPs are prepared to undertake this work; in private general practice it is simply not financially viable. Erosion of items such as the mental health planning items can only further repel GPs as well as causing further disadvantage to these already marginalized and disadvantaged groups.

In my other workplace, in a middle class Melbourne suburb I also use mental health plans for many of my clients. I reject any notion that GPs are using these items inappropriately. Psychological morbidity is extremely prevalent in the Australian community as is borne out in many studies and is acknowledged by the government and by other measures that are being put into place. GPs applaud these other areas where increased support for mental health services are proposed. However to do this whilst weakening the

front end (general practice) where most mental health care takes place is inexplicable.

I sincerely hope that Minister Roxon and the government give serious consideration to these issues and have the integrity and wisdom to reconsider their decision about how to proceed.

- I have been a GP looking after the community of [de-identified town] on the Mornington Peninsula for over 30 years. I have developed a special interest in mental health due to the frequency of such presentations but largely due to cost factors where patients could not afford private psychology plus the incredible lack of public services plus the lack of Psychiatrists, I was forced to "go it alone". Since the introduction of the wonderful 2710 etc, my and my patients lives and wellbeing have received a significant boost. I have been able to spend more time with them and refer them for expert counselling which has assisted enormously both doctor and patient. Because of the fact that so many of my patients are economically disadvantaged, ceasing this program (which is basically what the proposal means if you look between the lines) would be a disaster. At present I bulk bill all mental health item numbers, but I will no longer be able to afford that so my most disadvantaged patients will be out of pocket, but more importantly, I have no doubt will reduce their visits for assistance with their mental health. This will obviously increase morbidity and I am fearful mortality. Over a long time in GP I have experienced lots of government interference of a negative nature which has adversely impacted my care of patients but this undoubtedly has the potential to be one of the most disastrous.

6. References

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