

To: The Senate Standing Committee on Community Affairs

Dear Senate Committee

Summary

The Better Access program in my opinion has been highly successful in treating and rehabilitating patients and they and their families think very highly of the program. If there are problems with it, it is because the way it was implemented initially was not thought through properly and unfortunately I think that the same thing is happening now. My difficulty with the proposed policy is that it is 'throwing out the baby with the bath water'. In my view it would be better to retain what has been a very successful and effective program, but to make changes so that it operates more efficiently. The Gillard government's proposed changes are not doing this. I understand that the government would like the Better Access program to operate within budget and I make some suggestions regarding this in my submission.

After consideration I have decided to deliver my submission anonymously, not because I want to do this and I am happy to appear before the committee, but because I understand that my submission may be available to be read publicly and I am concerned about any ill feeling towards me from some of my non-clinical colleagues on account of some of the things that I will say here. This is in the context of the divisions within our profession at this time.

Submission

I am a clinical psychologist working in of around years experience. I am in independent private practice in a working-class suburb. I have been in part-time private practice for a long time, but have been doing solely private practice since about 2005, when I participated in the ATAPS program in three GP divisions, at that point it was a trial and precursor to the Medicare Better Access program.

I am going to make my comments from the perspective of a solo practitioner at the 'coalface'. I believe that more technical arguments will have been made by clinical psychologist colleagues and I see no value in repeating those. I will address the terms of reference that I consider relevant separately.

1. Changes to the Better Access Initiative, including:

(i) the rationalisation of general practitioner mental health services.

Although this is a matter for the AMA and the doctors there will most likely be consequences for psychologists and most importantly for our clients. The 50% cut to the MHTP rebate for GPs without mental health training I am assuming will impact upon the majority of GPs. I have heard GPs' representatives in the media, including the AMA, state that the consequences of this proposal will be that:

- a) GPs will write fewer mental health treatment plans and therefore there will be fewer referrals made to psychologists,
- b) When mental health treatment plans are written a copayment will be charged to the patient (this will of course disadvantage the most needy clients).

(ii) the rationalisation of allied health treatment sessions

As a clinical psychologist the work that I am referred tends to be reasonably complex. I don't know whether this is because the psychiatrists and GPs that know me refer such work, or because I am a clinical psychologist, or whether it merely represents a spectrum of the clinical problems out there, however, it is what happens.

When the Better Access program was introduced the intention was to address the anxiety and depression of patients who were frequent and recurrent presenters at GP practices. Thus it was meant to assist GPs, and it has done this very well. However, I think that the assumptions made by government at that time concerning the levels of severity and chronicity of these clients' disorders was inaccurate, that is it was underestimated. We all know that early intervention is the treatment of choice for all illnesses. If a patient presents to a GP with depression or anxiety and receives medication this is quite possibly reasonably effective early in the course of the disorder for depression (however not so much the case for anxiety). However, we know from research that over time without the addition of psychological treatments, medication alone will not resolve depression and anxiety. Therefore, the referrals that clinical psychologists receive for patients with depression and anxiety are for individuals who have developed chronic conditions because they have not received an early psychological intervention and these chronic conditions are by their very nature more difficult to treat. The notion that you could treat a chronic or moderate/severe depressive condition in six sessions per annum not plausible. You could probably do it in 12 sessions, but where there are other comorbid conditions or other complexities it can take 18 (however, this is not that common). But it is useful for the clinician, and extremely reassuring for the client to have those extra sessions available, a safety net if you like. It is important to note the number of sessions utilized is highest only in the first year and thereafter as the patient improves the number of sessions reduces until they are discharged. A bonus then is that amounts of medication also can be reduced, and sometimes patients can go off medication altogether with the support of self-management and relapse prevention plans etc, which are developed with clinical psychologists like myself. Nevertheless it is commonly considered that the treatment of a fairly complex disorder requires 24 sessions.

Therefore, there is a cost saving to the government, particularly from early intervention, but nevertheless from psychological treatment of mental disorders as an auxiliary treatment to medication. Working within the constraints of the Medicare system does make treatment necessarily active and focussed, however, you cannot push clients too hard before they are ready as this backfires. Some of them just require a bit of time.

(iv) the impact of changes to the number of allied mental health treatment services for patients with mild or moderate mental illness under the Medicare Benefits Schedule.

It has been pretty rare that I have seen patients without moderate severity, chronicity or complexity and who need six or less sessions.

The referrals to me under the Better Access program are largely for mood disorders (which is my major area of interest), namely bipolar affective disorder, perinatal depression, major depression, anxiety, and also schizoaffective disorder and schizophrenia. With respect to the latter two diagnostic categories, these clients are generally managed by psychiatrists who they see once a month or less, for maybe 15 minutes. (Psychiatrists are entitled to 50 sessions per patient per year). The illness is somewhat managed with medication, but these individuals are often left with residual psychotic symptoms, and with significant deficits in their overall well-being and lifestyle, neither of which are addressed as part of their treatment. In the State of Victoria you have to be extremely unwell and/or presenting as some sort of social problem to be admitted into the public mental health system. And if you are a client of that system (incidentally in which I worked for a long time), you are generally case managed, which is not treatment, and your condition may become stable but it also becomes chronic, mostly they don't improve. The patients that we have seen under the Better Access program include those who "fell between the cracks", not sufficiently unwell for the public mental health system, but not well enough for other services like community health centres, where by and large staff do not have the expertise to treat these kind of disorders. So, although initially unintended these chronic and moderately severe conditions have been referred to clinical psychologists in private practice, and have received outstanding treatment in my opinion and have moved fairly quickly down the path to rehabilitation.

These outcomes for patients are not possible within six sessions, nor ten (usually). I consider it very unfair (and arbitrary) that the biggest cuts, at more than 50%, that is from 18 to 10, are proposed for the individuals in our community who most need this treatment.

So where do people who have problems, but not severe mental illnesses go? The government's response to this question is that they can go to psychiatrists, the States' public mental health services and ATAPS. Psychiatrists are already very busy, and appointments are typically 15 min to half an hour. In any case, the work done by psychiatrists and by psychologists is completely different, with the psychiatrist generally focusing on issues regarding medication and mental state. There are very few psychiatrists who bulk bill and it takes some time to get into those who do, if you can get in. The State mental health system is already bursting at the seams. There are grave concerns that people with moderate to severe depression and anxiety related disorders will not be able to get into public mental health services, nor be able to get timely or affordable access to a psychiatrist or into ATAPS which we understand cannot accommodate all these people.

2. The impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program.

Having worked within the ATAPS program since 2005, I am quite concerned that the government proposes to use this program for the treatments of people with the more severe mental illnesses. I have worked with three GP divisions in Melbourne and there were problems in all of them. In one, 50% of the initial set up money went on administration costs. The individual employed in the coordinator position who liaised with GPs and managed referrals to psychologists worked part-time and was frequently unavailable, and this position 'changed hands' several times, often with considerable periods of time without the job being filled. There were also delays in payments because the accountancy position was not filled etc. There seemed to be always funding issues and all three divisions ran out of money during the financial year, one of them only halfway through the year.

The worst aspect of the ATAPS program was the paperwork and bureaucracy, and each division did things differently. The referral process was cumbersome, with delays and other complications due to processes and paperwork. Generally speaking, most GPs did not understand how the referral process worked and did not use it because it took up too much time and was overly complicated. I don't think that it was available to psychiatrists for referral purposes, in any case I never received such a referral. Another problem was that the number of psychologists/allied health employed by a division was capped. Despite being a clinical psychologist, there was one division which had tight gatekeeping and I could not gain access (it had mostly generalist psychologists and other allied health).

I also understand that most of the funding for this program will not be available until the fourth and fifth year, which raises the question of what happens from November until that time.

By comparison, the Better Access program is very easy-to-use and efficient. This means that for the GP with the patient in his/her office the referral can be made on the spot and most importantly within the window where the patient is ready and agreeable to attend a psychologist. Delays caused by paperwork and processes interfere with this process and patients who are already unwell easily give up and do not follow through.

The Medicare system has been set up for public access the services of healthcare professionals, has been operating for years, and therefore a lot of the difficulties with it have been ironed out. It is now largely electronic. With the capacity for practitioners to use EFTPOS facilities to bulk bill and charge patients (effectively) only the gap, making it more affordable for more people. It is a very efficient system with minimal paperwork and time wasting both for the practitioner and the client. If e-Health was introduced this situation would be even better. I know of no ATAPS program that operates electronically. C

Within Medicare GPs and psychiatrists are able to refer their patients to psychologists that they know and work with or to those who they know have a specialisation in a particular area, they are not limited

by the staff who are either employed or contacted by a particular division and they are able to make the referral directly. I believe that this is most beneficial to the client.

Within the Better Access system clients are able to come to sessions at times that best suit them. This is particularly important for mothers being treated for and recovering from perinatal depression who need their appointments to fit in with child care or other arrangements or appointments, or when their husbands are home from work and available to mind the baby and/or other children. Other patients need out of hours appointments, mostly in the evenings but also early mornings and Saturdays (or Sundays).

I consider myself pretty well informed, but I have been unable to find out how the proposed ATAPS scheme will actually work and what the availability of services to patients will be. I have also spoken to two coordinators for the ATAPS program at two GP divisions and they don't know either. I don't understand how this could be up and running by November. If it does go ahead, I think that we need at least a year for it to be set up properly, as well as a period of time for clients already in the system to complete their treatment. After all, they have contracted with us under the current arrangements to receive a course of treatment under the current conditions.

At any rate I don't see the point in moving away from the Better Access program within the Medicare system, which is working extremely well and achieving positive outcomes for clients, and spending a lot of money setting up a whole new and complex system where there is a history of a lot of problems to date, and most importantly, where too much of the money is not spent on clinical services to taxpayers.

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

I have largely addressed this issue in my above comments.

With respect to the coordination of services, in treating complex conditions in private practice I have really needed Medicare items that would encourage team care and liaison. For example, the Medicare items available to clinical psychologists only cover face-to-face consultations. There is no item number for telephone calls to other members of the treatment team, for assessments, for reports and letters, and particularly for case conferences, whether in vivo or via telephone or other technology. If you provide these services as part of your work, and I have done, you must do it for nothing, that is for no remuneration. I think that the absence of these item numbers is a mistake, as it does not encourage the teamwork and liaison that the government wants to see occurring.

With respect to technology, I support that the e-health system, and I would also like see some sort of software package that everyone could use and which was available to solo practitioners. When I last looked at this issue there were over 100 products to choose from, I looked at five, and none of them was really suitable for me. I ended up buying something off-the-shelf and developed my own system. None of this helps coordination of care.

4. Mental health workforce issues, including:

(i) The two-tiered Medicare rebate system for psychologists.

When the introduction of the Better Access program was first considered by the Howard government it only involved clinical psychologists as it was recognised that within the psychology profession these were the only psychologists who had specialist training in psychiatry/mental health and clinical conditions. This reflects differences in training and expertise. Clinical psychologists have a Masters or Doctorate in Clinical Psychology as mandatory, as well as two years supervised practical work, generalists do not and within this latter group there is a wide variety of training, including unfortunately all too often none in mental health. My point is that clinical psychology is the specialisation of psychology in psychiatric disorders, and the entire training is intensive and oriented to the treatment of *clinical conditions*. The higher rebate for clinical psychologists is endorsed by the Australian Psychological Society (APS) and was initially set through proper consideration in an industrial arbitration case in 2001. Clinical psychology is also recognised as a specialisation within psychology in the United States and Britain. I simply do not understand how those who are claiming that there is no difference between generalist and clinical psychologists could provide the evidence to back up this

inaccurate assertion. It seems to me that their motivation is the desire to be able to have the access to the higher rebate.

I understand that the major reason that generalist psychologists were included in the Better Access program at all was a workforce issue. There were simply not enough clinical psychologists to do the job. I understand that there are now 4500 clinical psychologists in the Clinical College, but I am not sure how many of these are working in private practice, and if there are others in private practice who are not College members. Also at the time of the introduction of Medicare rebates for psychologists the government established 5000 university training positions in clinical psychology, 1000 per year for five years, so that should be adding another 5000 to the clinical psychology workforce some time soon. In addition, some psychologists are availing themselves of the opportunity to upgrade their qualifications to clinical psychologist status through the various bridging programs which have been established by the APS. There is natural attrition, however the question is, how many psychologists do we need? I think that the government should look at this workforce issue again.

I believe that it was a major mistake to open up Medicare rebates to all registered psychologists, as well as occupational therapists and social workers. This was always going to blow the budget. I understand that the APS lobbied very hard for all psychologists to have rebates. It was a difficult issue for the APS as the majority of their membership is generalist psychologists. My understanding of the statistics is that the main area of the budget blowout occurred within the generalist psychologists. I have encountered and have heard from other colleagues a number of generalists who work under Medicare but do not have the mental health qualifications and/or experience to do so. The same applies to occupational therapists and social workers. There are generalist psychologists who have mental health training and experience who can do this work, but there are an awful lot who are not appropriate and who should never have been admitted into the Better Access program.

So rather than an arbitrary cutting of sessions to everyone by 50%, irrespective of what work is being done and where the significant contribution to patients' well-being is coming from, I think that this Better Access program should be modified with an expansion of sessions to clinical psychologist to 24 per annum, and a culling of the very large generalist group to those who have demonstrated training and expertise in mental health. No doubt, like many other clinical psychologists, I have had patients come to me from generalists, and have encountered generalists through my work who have an alarming lack of knowledge, and who are as a consequence negligent in their work, but they nevertheless take on work that they are not qualified nor equipped to do. This may be done in ignorance, but that does not make it okay. An example that I encountered was of a client presenting with psychosis, who was given no diagnosis, and when the client should have been referred to a psychiatrist for appropriate antipsychotic medication, they were instead given focused psychological strategies and seen 11 times.

Bulk billing of clients.

Currently with the clinical psychologist rebate of \$120 I am able to bulk bill many clients, especially those with complex and psychotic disorders. This is particularly beneficial for those individuals who are unable to pay a gap, that is, those with a disability support pension or who are unemployed etc. Arguably the worst outcome of the proposed removal of the clinical psychology specialist rebate is that these clients will not be able to be bulk billed, and will therefore no longer be able to be seen. I am particularly concerned about patients with complex presentations who I am currently seeing, especially those who have begun treatment fairly recently. All I know is that on November 1 the situation will change, and I have been given no information regarding what will happen to these patients who have contacted with me under the old arrangements. Patients in treatment already are understandably distressed and you need to understand that this has a destabilising effect on their mental state and can actually precipitate relapse and undo some of the good work done. With the current economic situation and people "doing it hard" this is a very bad time to be cutting services to those who need them most, but also to working families who are experiencing increasing costs, and therefore introducing additional stresses to people already under strain.

Yours sincerely

Name withheld, Clinical Psychologist

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