

Submission

To: **Senate Community Affairs References Committee inquiry into Commonwealth Funding and Administration of Mental Health Services**

“The Senate Community Affairs Committee has concluded that there are no grounds for the two-tiered Medicare rebate system for psychologists and recommends the single lower rate for all psychologists including clinical psychologists”

Summary:

Proposal for rural communities to have a safer transition from Better Access to the extended ATAPS initiative, and no further cuts to the Medicare rebate for clinical psychologists.

Background:

Please find attached reply from the DoHA to my letter to the PM about budget cuts to the Better Access program. I wrote about the danger of an implementation lag for the government's new mental health initiatives and the adverse impact this may have on my NSW rural patients. For Leeton, Narrandera and surrounding areas, there is only one generalist psychologist and a social worker working under the current ATAPS program and myself as a private clinical psychologist under the Better Access program.

According to the DoHA letter, the current ATAPS program and private or public psychiatrists can take up the slack from cuts to private psychologist services from 1 November 2011. They mention that a private psychiatrist can see each patient up to 50 times a year. This simply won't work in my region. Patients have to travel huge distances and wait at least 6 to 18 months to see the nearest private psychiatrist. They can be referred to the local GP Network's visiting psychiatrist, but she only visits at best one day a fortnight. The public psychiatrist also used to visit one day a fortnight, but patients had to go through at least 2 triage layers to see him (ie. crisis line referral and screening by a mental health worker). The waiting periods for visiting psychiatrists in this region are understandably long, so the only intervention possible is pharmacological. There is simply not enough time for them to provide talking therapies as suggested in the DoHA letter. An exclusive biological focus on mental health can attract criticism about the violation of human rights (<http://www.cchr.org/about-us/mental-health-declaration-of-human-rights.html>). To ensure an integrated bio-psycho-social approach standard for mental health, it is necessary to more adequately fund and provide talking therapies.

In this region, public mental health workers only have enough time to (a) assess new cases referred by their telephone crisis service, (b) support a small number of patients who are on community treatment orders, and (c) complete extensive paper work for the national data base. Almost half their time is wasted on a national data collection system that, as far as I am aware, has never produced a single research paper about mental health. I have worked as a mental health worker for more than a decade in the ACT, SA and NSW. About 6 years ago I began working in this region as one. Most mental health workers tend to be general nurses or counsellors with TAFE certificates, so they are unable to provide talking therapies to the same standard as psychologists who have had from 6 to 8 years of formal training in these clinical techniques.

Leeton and Narrandera now only receive an outreach service from the local Community Mental Health Service that is based about an hour away at Griffith. Patients can only see a public psychiatrist for treatment if they are unwell enough to be scheduled to the acute psychiatric unit at Wagga Base Hospital (eg. suffering psychoses, self-harming, suicidal or homicidal). On discharge they may have to wait 3 to 6 months for a follow up session with a visiting psychiatrist. Contrary to what was suggested in the DoHA letter, most people who are referred to a community based mental health service, never actually get to see a psychiatrist or even a psychologist for that matter.

ATAPS stands for “access to applied psychological strategies”. The federal government funds this program and local GP Networks run it. The cost of funding a psychologist session under ATAPS is far more expensive than through the Better Access program, even when the latter is with a clinical psychologist. Criteria for referral to the current ATAPS in my region exclude anyone with a chronic major mental disorder. Those with mild to moderate mood disorders are restricted to only 6 sessions, with provision for another 6 sessions if absolutely necessary. This may look like better access to a psychologist than the Better Access program (soon to be only 6 sessions with another 4 sessions if approved by the GP). Of course waiting periods in this region are expected to increase for ATAPS after 1 November 2011. This is because I can no longer take referrals that might go beyond 6 sessions or even 10 sessions. Referrals are based on a GP Mental Health Care Plan, but there is no provision or stipulation in the plan about how many sessions are required. This is understandable and often a reason why patients are referred to a psychologist in the first place. Thus, contrary to what has been suggested in the DoHA letter, the current ATAPS program is unsuitable for people with a chronic major mental disorder or moderate to severe disabilities arising from their illness.

The government has promised to fund an extended version of ATAPS over the next 5 years with a multi-disciplinary team to manage chronic mental illnesses with unlimited treatment sessions. Although my local GP network has been one of the first to establish a Medicare Local, the responsible officer was unable recently to give me any idea when they would be ready to recruit the multi-disciplinary team or the coordinator to broker clinical services for the more severely mentally ill. This is the hub of my concern. Who is going to look after this vulnerable group of patients after 1 November 2011?

The DoHA letter criticised the Better Access program for failing to adequately service indigenous people, youth, rural patients and men. However, I see all of these groups and probably slightly more men than women. I did not participate in the Better Access program evaluation, but the conclusions drawn to justify cuts from a single study seem dubious, especially when they don't appear to adequately represent rural services. There should have been an additional examination of Medicare statistics and even a comparative evaluation of private psychiatric services.

When NSW WorkCover reforms were introduced in 2010, fees were capped 30% below the APS recommended fee and the cost of accessing their city based mandatory day workshop was over \$1,000. It was no longer viable for me to do that kind of work and it would have been a waste of money to do their training. So for ethical reasons I continued to see a number of existing patients for free. I don't want to be caught again working for nothing, so I have stopped taking any new referrals.

Position:

As a clinical psychologist, GPs have been referring their more difficult cases to me. In particular, those that fall outside the current ATAPS criteria. The evaluation averages cited in the DoHA letter and their minimisation of the problem do not apply to my region. At least half of my case load consists of patients with a chronic mental illness and most of these have moderate to severe disabilities (eg. bipolar disorders, schizophrenia, borderline personality disorders, obsessive compulsive anxiety disorders, and patients with recurrent depressive and dysthymic disorders, etc). Many are involved to some degree with the local public mental health service. Quite a few have recurrent acute mental episodes. Through collaboration with local GPs and mental health services, these patients can be reviewed by one of the visiting psychiatrists. They certainly require more than 10 sessions of psychological therapy a year and many would benefit from the more intensive and multi-modal interventions promised under the new extended ATAPS initiative. However, we know that this new program will take time to establish, possibly 1 to 2 years for my region and maybe even longer where communities have yet to establish their Medicare Locals. Recruitment of allied health

practitioners has always been problematic for rural communities like this one and there are regrettably no special incentives to attract them here. In the meantime, who is going to look after my chronically mentally ill patients after 1 November 2011? Why can't the government wait for the new ATAPS initiative to be up and running before cutting Better Access? It just feels like the government has pulled the rug from under the most vulnerable patients.

Finally, if the clinical psychologist rebate is abolished, then it will no longer be viable for me to run a private practice in this rural region. I can't even get a mechanic to work on my car for less than \$90 per hour and local plumbers want that much for just 15 mins work to change a tap washer. I spent a lot of money and several years of my life studying part time for my Master of Clinical Psychology degree. To pay for that investment, I have been bulk-billing all my patients to earn just under \$120 per session. A session for me can range from 1 to 2 hours. The first few sessions are always longer because most patients have a history to communicate.

The standards for my profession continue to rise, but the work is actually under valued and certainly under paid. Requirements for specialist registration like mine now require a doctorate or a 7 year degree, yet employers are happy to fill generic mental health positions with less qualified and less experienced staff. Running a small business on Medicare rebates does not compare with a salaried job like a mental health worker in NSW. The latter is far better paid, but the work does not reflect or satisfactorily use the skills and knowledge of a clinical psychologist. The problem is not the 2-tier system of Medicare rebates. Rather it's the inadequate value and remuneration for the work and seniority of both generalist and clinical psychologists. For example, the rebate for the first consult with a psychiatrist is considerably more than for subsequent sessions, so why is the rebate for our first consult the same as every other session? Clinical psychologists like psychiatrists still have to take an exhaustive history to complete their assessment. Even a mental health worker employed by a state government takes at least 2 hours for their initial structured assessment, so why can't the Committee look at this kind of comparative work value? I hope the Committee is not just interested in cutting costs. The focus should really be on fairer remuneration for both generalist and clinical psychologists?

Conclusion:

We need a more sensitive and timely transition to the extended ATAPS initiative. Otherwise, the impact of cuts to the Better Access program will be devastating for some of my patients. I have already stopped taking any new referrals, so there will be people in this region who are already unable to access appropriate mental health care. If the clinical psychology rebate is abolished and there is a further rebate cut of 30%, then I will have no choice but to wind up my rural practice as soon as practical. This will be a travesty for some of the most vulnerable people in our region.

Thank you for your consideration.

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Clinical Psychologist,

4 August 2011



Australian Government
Department of Health and Ageing

Mr Trevor Cocks
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Dear Mr Cocks

Thank you for your correspondence of 1 June 2011 to the Prime Minister, the Hon Julia Gillard MP regarding the recent changes to the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) initiative announced in the 2011-12 Budget. This matter falls within the portfolio responsibility of the Minister for Mental Health and Ageing, the Hon Mark Butler MP. The Minister has asked me to reply on his behalf.

The 2011-12 Budget provided a record investment of \$2.2 billion over five years in new and expanded mental health services. Included in this investment were some changes to the Better Access initiative.

The Australian Government is concerned that while Better Access is a good program for those it is reaching, it is still not servicing hard to reach groups like young people, men, people living in rural and remote regions, Indigenous Australians and people living in areas of high socio-economic disadvantage. In fact the evaluation showed that people on lower incomes received both significantly less services and funding under Better Access than those on higher incomes.

From 1 November 2011, the cap on Medicare rebates for eligible people with a diagnosed mental disorder will be changed from 12 sessions per year to ten. Following the initial course of treatment (a maximum of six sessions) consumers will be able to access four more sessions. Consumers are also eligible for ten group sessions per calendar year in addition to their individual sessions.

In making these changes the Government has listened to mental health experts and examined the available evidence, including the independent evaluation of Better Access. After more than four years of operation, the Government has a clear sense of how the program is being used by providers and consumers.

The findings of the Better Access evaluation showed that almost three-quarters of people who access services used between one and six sessions a year. The majority (87 per cent) of current Better Access users received between one and ten sessions and will therefore be unaffected by this change.

People currently receiving services under Better Access will be able to access up to 12 individual and/or up to 12 group sessions prior to 30 October 2011. In exceptional circumstances, and where there is a clinical need, they can access an additional six individual services prior to 30 October 2011.

From 1 November 2011, the new arrangements will apply. Individuals who have already accessed ten or more individual and ten or more group services by 1 November 2011 will not be eligible for additional services until 1 January 2012.

The Department of Health and Ageing is working on implementation arrangements and further information will be made available to consumers and providers in the near future.

It is important that people get the right care for their needs. People who currently receive more than ten allied mental health services under Better Access are likely to be patients with more complex needs and would be better suited for referral to more appropriate mental health services. GPs can continue to refer those people with more severe ongoing mental disorders to Medicare subsidised consultant psychiatrist services, where 50 sessions can be provided per year, or state/territory specialised mental health services.

Every cent generated from the changes to Better Access is being redirected to double the number of services targeted at vulnerable and hard to reach groups through the Access to Allied Psychological Services (ATAPS) program, as well as investing in additional services for early intervention youth services and improving the coordination and accessibility of services for individuals with severe mental illness.

The Government does not take the decision to make changes to Medicare services lightly, but given the tight fiscal environment it has a responsibility to ensure that its investments are appropriately targeted to ensure maximum value.

Under the ATAPS program, the Department of Health and Ageing funds Divisions of General Practice to allow GPs to refer patients who have been diagnosed as having a mental disorder of mild to moderate severity to an allied health professional to provide short term focussed psychological strategies services. ATAPS services are targeted to those individuals requiring primary mental health care who are not likely to be able to have their needs met through Medicare based mental health services and address service gaps for people in particular population gaps and in particular geographical areas such as rural and remote areas.

The 2011-12 Budget included almost \$206 million over 5 years to significantly expand the ATAPS program. This expansion will support an additional 184,500 people, with a particular focus on the most vulnerable including children, Indigenous Australians and people from other hard to reach groups including people living in low socioeconomic areas.

Funding for people living in low socioeconomic areas and other hard to reach groups was rolled out from 1 July 2011 under existing arrangements with Divisions of General Practice transitioning to Medicare Locals as these are established and demonstrate capacity to deliver mental health services. These transition arrangements will focus on service continuity. The number of services available under ATAPS is unchanged.

In addition, in the 2010-11 Budget the Government committed to provide flexible care

packages to better support people with severe mental illness in the community. The Flexible Care Packages for People with Severe Mental Illness measure is being implemented in a staged approach to coincide with the establishment of the first 19 Medicare Locals from 1 July 2011.

In addition, as announced in the 2011-12 Budget on 10 May 2011, the Government will invest \$343.8 million over 5 years in better coordination and more services for the severely mentally ill – so that 24,000 Australians trying to manage a severe and persistent mental illness will have assistance to access better coordinated, more comprehensive care and support.

The new coordinated care arrangements will build upon and include Flexible Care Packages from 2012-13, offering additional support, assessment and coordination as well as non-clinical services.

More information about these and a range of other initiatives can be found at www.health.gov.au/mentalhealth

The Prime Minister, the Hon Julia Gillard MP, stated last year that mental health reform would be a priority for this term of government. The 2011-12 Budget delivers on the Gillard Government's commitment to make mental health a priority.

The Australian Government has heard the voices of the millions of Australians who have experienced mental illness, their families, their carers and the experts, and this package takes action on their advice.

The Government has provided, through the largest mental health investment in the nation's history, a \$2.2 billion investment over the next five years to drive fundamental reform in Australia's mental health system. This investment was informed by extensive engagement with experts, service providers and consumers and carers.

The *Delivering National Mental Health Reform* package consists of initiatives from across a number of portfolios, including:

- \$549.8 million to provide coordinated care and flexible funding for people with severe mental illness and complex multi-agency care needs. This will provide eligible individuals with a single point of contact, a care facilitator, and will assist about 24,000 people and their families;
- \$491.7 million for prevention and early intervention mental health services for children and young people;
- \$227.6 million boost to community mental health services, including additional funding for Day to Day Living providers, the Personal Helpers and Mentors program and for extra respite services and support for the carers and families of people with a mental illness;
- \$205.9 million, through an expansion of the Access to Allied Psychological Services program, to better reach groups who continue to miss out on Medicare funded services, such as people in rural and regional areas and low income areas, Indigenous Australians, young people under 25 years and other hard to reach groups;
- \$14.4 million to establish a single mental health online portal and to expand the services provided by the proposed e-mental health clinic;

- \$2.4 million to increase economic and social participation for people with mental illness. This will be supported by \$50 million for more personal helpers and mentors to support a return to employment, plus almost \$26 million over three years to support the very long-term unemployed with a mental illness through the *Building Australia's Future Workforce* budget package; and
- \$201.3 million to encourage the states and territories to invest more in mental health priority areas and address service gaps, including in accommodation support and presentation, admission and discharge planning in emergency departments.

The Government is also investing a total of \$32 million to establish a National Mental Health Commission to increase accountability and transparency in the mental health system. The Commission will provide leadership and drive a more transparent and accountable mental health system in both the health and non-health spheres, and provide an Annual Report, through the Prime Minister, to Parliament.

Included in this record investment over the next five years is \$1.5 billion in new expenditure and \$624 million from the 2010 Budget and election commitments in mental health.

If the Government's mental health investments in subacute care beds, the Health and Hospitals fund and specialist training places are included, the total investment in mental health over the next five years is in fact \$2.5 billion.

The *Delivering National Mental Health Reform* package is a cross-sector reform package that recognises the diverse impact of mental illness throughout a person's lifetime and will build resilient kids, support teenagers and families dealing with the challenge of mental illness, improve access to primary care and target more community-based services to people living with severe mental illness and their families.

Importantly, the Government will work further with the states and territories, mental health consumers, carers, experts, and leading advocates in the mental health sector on the detailed implementation of the 2011-12 Budget measures and in the preparation of a Ten Year Roadmap for Mental Health Reform.

The Roadmap will set out an agenda for long-term reform of the mental health system. It will signpost our efforts to reform the mental health system, ground investments in the advice of experts and stakeholders and commit the Government to ongoing action.

I trust that the above information is of assistance.

Yours sincerely

Virginia Hart
 Assistant Secretary
 Mental Health Services Branch
 8 July 2011