

Commonwealth Funding and Administration of Mental Health Services

Senate Inquiry: Community Affairs References Committee

I would like to submit the following comments to the Senate Enquiry referred to above, under the following headings:

The terms of reference are:

The Government's funding and administration of mental health services in Australia with particular reference to:

1. The Government's 2011-12 Budget changes relating to mental health;

Co-ordinated care packages/Tier 3 ATAPS: In relation to the delivery of co-ordinated care packages which are due to commence shortly (originally announced 2010-11 Budget and added to in the 2011-12 Budget) for those people with more severe or persistent mental disorders, it would be preferable to place the funding of these into the new primary healthcare organisations (Medicare Locals) as they are the only ones who have both good connections with General Practice, but also an overview of what NGO or CMO mental health services are available in their area and experience of joining multiple services together in the provision of patient care. They have multiple years experience of co-ordinating ATAPS services for patients referred by GPs and for undertaking higher than average levels of communication and ability to work with GPs and hence it would make more sense for whoever holds the ATAPS contract to also run Flexible Care Packages either directly or indirectly as a natural extension of ATAPS services. The NGO sector run very good programs for mental health consumers from a social or vocational perspective, links with whom will be vital to the success of this initiative, but they do not have the necessary primary care focus or knowledge of clinical care delivery that will also be an important part of this initiative.

2. Changes to the Better Access Initiative including:

- a. the rationalisation of GP mental health services;
- b. the rationalisation of allied health treatments sessions;

A clear distinction should be made when determining the levels of access to services provided by clinical psychologists (those with specialist training) who are equipped to effectively and based on current evidence see those people with more severe, complex and multifactorial presentations compared to access for those people requiring generalist counselling or supportive strategies, such as provided by psychologists and others with an undergraduate degree. If this distinction is not corrected in the next iteration of the Better

Access program, it is tantamount to saying that postgraduate training is of no value, a premise that would be difficult to substantiate at any level.

- c. the impact of changes to the Medicare rebates and the two tiered rebate structure for clinical assessment and preparation of a care plan by GPs;

While understanding the fiscal necessity surrounding this change to Medicare rebates for care plans by GPs, it would be an undesirable and untoward outcome if the result was that GPs were less able or less willing to undertake this process with their patients. While there are flaws in the current system e.g. care plans that are prepared in a cursory manner, often missing important and relevant information, the role of the General Practice must remain central to overall health care and the care co-ordination that sometimes requires. Would the Government consider a role for Clinical Psychologists to take over some of the clinical assessment and care planning in conjunction with GPs, as this is a core set of skill for this group of providers.

- d. 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 (MBS);

The Better Outcomes program review did show that 10 sessions is likely to be enough for most people with mild to moderate presentations. Where it will have the most impact is on the care of people who do not require flexible care packages, but do require longer access to clinical care. This differentiation has not been made when consideration of limiting session numbers were made. The policy of providing for those people with more severe, complex or enduring difficulties under Flexible Care Packages has been articulated, but they will not get this care provided appropriately unless organisations running those services (Medicare Locals being the obvious fund holders) are able to engage clinical psychologists to manage, oversee and provide those services.

3. The impact and adequacy of service provided to people with mental illness

through the Access to Allied Psychological Services program (ATAPS) program;

Many aspects of the impact of this service have been systematically studied and evaluations thoroughly written up in the 17 Evaluation Reports completed by the University of Melbourne since inception of this program. In terms of primary care reform, it was and remains instrumental in having services available nationally to people who were not previously able to access services at all and is the forerunner of the Better Access program, which unfortunately did not have many quality measures built in from its inception, although it is widely available in metropolitan and some regional areas, but not so accessible in areas beyond that.

Additionally, ATAPS has provided the platform for the very successful addition of programs

demonstrated to meet previously unmet need e.g. via the Perinatal Depression Initiative, services for those struggling with suicidal ideas or self harm, services for children and families and those affected by extreme climatic events. The responsiveness of this program on a local level is unsurpassed and has become a valuable addition to the mental health referral services available to patients being managed in primary care. There is some further work to do on the eligibility of clinicians to provide this service, as all those currently eligible do not have the necessary postgraduate clinical training required to be skilled in seeing the complexity of presentations referred.

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

See comments in 1. about fund holding model for these services

5. Mental health workforce issues including:

- a. the two-tier Medicare rebate system for psychologists;

Please see comments outlined in (b) below that covers this question

- b. workforce qualifications and training of psychologists;

There seems to have been a fundamental lack of understanding at Government and other levels about the ability of various “types” of psychologists who can provide clinical services, be it under the Better Outcomes or Better Access Mental Health programs.

Psychology, unlike any other allied health discipline does not produce clinically trained graduates after a 4 year degree who have been taught the necessary skills to treat people in a clinical setting. This is different to other allied health professions e.g. social work, physiotherapy, dietetics whose undergraduate training is sufficient for them to commence work as a clinician upon graduation. A four year psychology degree in Australia is the platform from which many specialist skills can be acquired e.g. in education, forensic, neuropsychology, clinical or other settings, but does not in and of itself produce graduates who are clinically competent.

To become a specialist in the area of clinical psychology, postgraduate clinical training is the minimum requirement. In all other developed English speaking countries in the world postgraduate qualifications of at least 2 years minimum is the entry level to clinical work. Training in clinical work is intensive, comprehensive, assessed and reviewed across a broad range of settings, in both theory and practice. It is specialist training in a similar vein to specialist medical practitioners.

Unfortunately, some confusion has crept in with the registration of psychologists whereby undertaking a postgraduate degree of 2 - 4 years duration **or** having some regular hours

of supervision in a workplace under the 4+2 scheme managed by previous state registration boards was deemed “equivalent” in that they both led to registration. Since psychologists have been eligible to apply for a Medicare provider number, there has been more blurring of what constitutes clinical psychology, with those psychologists without specialist training arguing for equivalence, which clearly does not make sense when we look at other precedents in health care, nor is it equivalent as soon as the differences in training are properly understood.

For example, 20+ yrs ago, GPs were required to be vocationally registered to become an accredited General Practitioner, with postgraduate training now being the only pathway to vocational registration. GPs can remain non-vocationally registered, attracting lower Medicare rebates as an acknowledgement of their lower levels of training and presumably commensurate skill levels. Similarly with specialist medical practitioners, they are required to undertake considerable and rigorous postgraduate clinical training and supervised practice after completion of their undergraduate medical degree to be eligible to be called a specialist. Those doctors who chose not to undertake this training can be employed as Career Medical officers or in other medical jobs, but would not legitimately be able to offer “specialist” services.

The analogy is that postgraduate Clinical Psychologists are more like vocationally registered GPs or specialist medical practitioners and should be acknowledged as such via the services they have been trained in and hence are allowed to offer and by way of higher levels of remuneration that recognises the training they have undertaken and adjudicated standard that has been reached and by acknowledgement of the need to greater access to them based on complexity of presentations.

c. workforce shortages

As is the case with all medical and allied health professionals, there is an unequal distribution of providers the further one moves from metropolitan areas. Unfortunately the Medicare fee for service model exacerbates this iniquitous access to health care, as people can only access fee for service health care where there are providers present. This means by definition that people in metropolitan areas have greater access. Much support in recent Government mental health policy has been provided for alternative funding of health care e.g. via ATAPS, MAHS, and other programs and has been demonstrated to help reduce the access inequity and should be further supported, while acknowledging there is additional work to be done in this domain of equalising access. Telehealth and internet based health care are a useful adjunct to care, but still only part of the picture and will never be the complete answer as some people will need to be in touch with a provider face to face, especially where psychological care is the focus.

6. The adequacy of mental health funding and services for disadvantaged groups including:

- a. culturally and linguistically diverse (CALD) communities;
- b. indigenous communities; and
- c. people with disabilities

7. the delivery of a national mental health commission;

8. the impact of online services for people with mental illness, with particular regard to those living in rural and remote locations and other hard to reach groups;

This is an emerging area of development in the delivery of psychological inputs for people who do not have easy access to face to face providers. While it may have a place as a useful adjunct, the research of efficacy is in the early stages and care needs to be taken in seeing it as the universal panacea for people in rural or remote locations.

The other aspect of online services which is important is that it can obviously be managed from any location, so the providers do not have to be located remotely in the same way as for face to face work, which is a great advantage, if the approach is used wisely and in line with the evidence.

9. Any other related matters.

It is my opinion that all parts of the system that currently provide mental health care have a valuable part to play i.e. state funded services, commonwealth funded (Medicare) services, private practice and primary care. It seems that when there are any changes to the system, for example by a Government Budget, the first thing that happens is that they all go into competition with one another. It would be fruitful if there were more mechanisms built into each sector which enhanced their ability and motivation to work together, particularly where the client or patient's needs may be best met by various parts of the system at different times and better communication between those different parts of the system would be advantageous. Incentives to work together, adequate remuneration for shared care and not just fee for service when the patient is in front of the clinician would all add to better overall care.

Clinical Psychologist
25th July 2011