Community Affairs, Committee (SEN)

The Committee Secretary
Senate Standing Committee on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600

4th August 2011

Dear Sir/Madam

Re: Commonwealth Funding and Administration of Mental Health Services

As a Counselling Psychologist of some twenty years standing and working simultaneously in both the public and private sectors, I trust that the inquiry will truly focus on the funding and administration of mental health services **as needed for and by those suffering from mental illness**. Many sufferers are unable to adequately represent their needs, especially to this type of inquiry.

I have chosen to maintain a part-time salaried position to ensure that I am accessible to a large group of disadvantaged youth and adults and I am in private practice providing psychological services to adolescents, adults, couples and families. I have an average private practice and I thought that it may be of interest for the Committee to have some basic statistics. Of my current patients some 75% had diagnoses of severe mental illness affecting daily function and 25% required assistance in the area of relationships. Of my current patients, 38% suffer severe Depression, of whom 45% are chronic sufferers; 17% have Post-traumatic Stress Disorder and 19% suffer severe Anxiety Disorders, of whom 42% have chronic conditions. Some 13% have co-morbid Personality Disorders. Of my current patients, 63% receive Medicare funding with 65% of these being bulk-billed, 2% receive ATAPS funding. The remaining 35% are funded from other sources or are self-funded. The 65% of Medicare patients whom I bulk-bill would not be able to access a Psychologist without Medicare funding. In order to meet the demand for Medicare funded services I have withdrawn from some other aspects of my work. I could reinstate this work at any time. I am not dependent upon Medicare funding. However, many of my patients are desperately dependent upon Medicare funding.

Term of Reference (a)

Overall, the Government's budgetary changes provide an inadequate response to mental health needs in Australia. Mental illness exists to widely varying degrees from Childhood conditions, through reactive illness, such as Post-traumatic Stress Disorder, milder forms of Depression, Anxiety and Phobic disorders, through Personality disorders to severe, chemically-mediated disorders such as severe Depression, Bipolar Disorder and Schizophrenia. Within the various categories of illness there is wide variability of presentations from mild and moderate to severe and extreme. There is the need for assessment, diagnosis, case formulation, therapeutic treatment, skills development, relapse prevention and maintenance, along with early intervention and preventative approaches. Those with severe mental illness do not always function well in the community and often have additional needs for daily care, frequent support, housing, employment, training and recreation. **Any decent mental health system**

must cater for all these needs. Instead we seem to have a great deal of professional competition occurring to gain a piece of an inadequate funding pie and excessive creation of administrative bodies or systems which take a slice of the funding away from those who most need treatment and support.

Term of Reference (b)

The Better Access Initiative has been of greatest value in helping Psychologists to address decades of neglect of those with mental illness and has helped to lower the stigma associated with mental illness. Many patients with mental illness are now accessing psychological services, are recovering and are learning relapse prevention skills to maintain their mental health or minimise the impact of any future relapse. Many are talking to family, friends and acquaintances about their experiences and encouraging others to seek professional help, thus helping to lower the stigma associated with mental health issues.

I believe that, over time, the demand for psychological therapy will gradually decrease as educational programs are taken into school settings and more people are trained through therapy to maintain mental well-being, resulting in eventually reaching a plateau related to a reduced incidence of mental illness/relapse. In the meantime, we are still catching up on a large backlog. I am seeing patients who have stayed at home suffering from Depression or Anxiety for decades. I am seeing patients with Obsessive-Compulsive behaviours that they have had for decades. I am seeing patients with Personality Disorders who have had health, employment and social difficulties for decades. The good news is that many have recovered sufficiently to lead happy and productive lives. Some are now making vast differences in their children's lives by teaching their children the skills that they have learned. Several times each year since Medicare rebates were introduced for Psychologists, I have identified Psychosis and Bipolar Disorder in those who did strange or embarrassing things and "hid and worried for years, but didn't tell anyone" of their cyclic symptoms for fear of ridicule and the stigma of "going crazy". For the government to cut back funding for mental health at this stage is a truly serious retrograde step that can be expected to have future implications. Mental illness and mental health are long ranging issues over lifetimes, just as are physical illness and physical health.

I understand that it is intended to reduce the number of sessions available to 10, because most patients were not using in excess of this number. If the sessions were not being used, they were not costing the Government anything, so it is ridiculous to jeopardize the well-being of the small percentage of patients who needed up to 12 to 18 (or more) sessions per year. Please re-instate the further sessions to six and the option for GPs to authorise an additional six sessions under exceptional circumstances. We just cannot adequately treat long-standing and the more severe conditions over 10 sessions. This can be more detrimental than no treatment at all, because inadequate treatment can result in negative cognitions, affect and behaviour being reinforced rather than extinguished. This has been the case in the past for many patients who may have managed to pay for services for a brief period and had to desist from treatment due to cost issues. We are now repairing this damage. Please note that I have voluntarily provided ongoing sessions, in excess of the allowed 18, free of any charge for several bulk-billed Medicare clients in order to prevent them from relapsing and suffering further damage. It will not be viable for me to do that if

there are only 10 sessions available in a year. I trust that Psychologist professional bodies are providing further research information regarding session numbers to the inquiry.

Term of Reference (c)

From my observations and understanding, much of the ATAPS funding in my area has and is being used to pay salaries for administrative staff to create and manage systems to oversee the allocation of funding. There are widely differing administrative systems in each of the three GP Divisions for whom I provide services. Some systems are too complex, are time consuming for all involved and, in my opinion, are a waste of good funding. Not all GPs access the funding, and there is limited funding resulting in an inequity in the distribution of the funds. There is increasing use of the funding for creating untested group programs operated by staff within the divisions and for creating publicity materials to advertise the programs to GPs, Psychiatrists and Psychologists in order to try to gain sufficient interest to actually run the programs. I really question how much of this funding is actually providing direct and helpful treatment for patients. While there is certainly a need for additional funding for severely financially disadvantaged patients, perhaps it would be more equitable for this to be managed through a higher Medicare rebate for those on a Government Health Care Card and an access requirement to ensure bulk-billing for these patients.

Term of Reference (e)

Australia currently has an excellent mental health workforce providing services, although there are skill and funding shortages. I understand that there is a serious shortage of GPs and of Psychiatrists in Australia. I, therefore, do not understand why we take up their precious time in filling out a large amount of administrative paperwork. They need to be free of excessive administration, in order to provide direct service to patients. Currently GPs are completing Mental Health Care Plans with patients and are appropriately renumerated for this work. Any expectation for the funding for this onerous assessment task to be reduced must be met by an equal reduction in the size of the task. Psychologists do undertake their own comprehensive assessment with patients from a psychological perspective, thus the Mental Health Care Plan administrative and information collection system may need review.

There is a well-qualified and wide-ranging network of Specialist Endorsed and Generalist Psychologists throughout Australia available to provide high quality assessment, diagnosis, therapeutic treatment, relapse prevention planning and maintenance assistance. This workforce has been better utilized over the past few years, as funding was made available for patients to access evidence-based psychological therapy. Psychologists throughout Australia have been working to catch up on providing therapeutic treatment for the vast number of patients suffering from mental health disorders who have been neglected for more than forty years through a previous paucity of government funding for mental health.

Given that the funding pie has a limited size, priority needs to be given to direct services for patients rather than to complex and unnecessary administrative systems or excessively administrated organizations that do not directly benefit those with mental illness. The funding pie needs to be provided for patients to access those services that can best help them to recover from temporary mental illness and can teach the necessary skills to manage chronic mental illness and prevent relapse; that is generally

achieved through evidence-based psychological therapies. The Committee has previously looked at the research evidence that psychological therapy works for those with mental illness. On behalf of sufferers, I beg the Committee to ensure that the most appropriate and available providers of services are funded adequately to enable those with mental illness to access the services they need. Please let us not fund something just because it seemed like a good idea at the time or because of self-interested lobbying or because it is a cheap option.

Term of Reference (e) (i)

In considering the two-tier system of Medicare benefits for psychologists from a consumer patient point of view, it is more equitable for the patient to receive the same level of government benefit no matter which psychologist is seen. Natural market forces can then help to determine which type of psychologist, if any, is providing the 'better' or 'more qualified' service. Specialist Endorsed Psychologists do have a higher level of training and supervised experience than do Generalist Psychologists and often charge a higher rate in order to recoup the costs of a greater number of years of study, supervision and expertise maintenance. Equitable patient access to these Specialist Endorsed Psychologists can only be facilitated through the two-tier system by providing a higher rebate for specialist services. Clinical Psychology is just one of the endorsed specialties, with Counselling Psychologists and other Specialist Endorsed Psychologists also being extensively trained to provide assessment, diagnosis and evidence-based psychological therapies for mental health disorders as approved under the Better Access Initiative.

If a single tier of funding is decided then it needs to be of an amount that is viable for patients to still be able to access the services they need. Overall, both the current Medicare scheduled fee and benefit are woefully inadequate and many patients struggle to afford the Psychologist's actual fee. Sessions need to be of approximately one hour for effective psychological therapy. Shortened session times are not an appropriate option. Please compare the Medicare benefit rate to the current basic rates that are paid equally to both Specialist Endorsed Psychologists and Generalist Psychologists for Work Incident and Transport Accident patients, along with Employee Assistance Program rates being paid by both State and Federal government departments to keep their own workforces in good mental health. Both the Medicare scheduled fees and benefits for psychological services need to be increased to provide parity and equality for patients.

The work of Psychologists with patients is not just about funded sessions. Psychologists have to undertake many other hours of unpaid work in the form of administrative tasks such as reports to doctors, sourcing additional services required by patients, consulting and coordinating with other services, providing letters for patients, completing documents for patients, along with responding to urgent needs outside of session times. All of this is unfunded and unpaid work.

I would like to confirm to the Committee that I, like most other Psychologists were in successful private practices prior to the Better Access Initiative and I will continue to see many non-Medicare-funded patients. **The Initiative was not about being funding for Psychologists. It was about providing equity, creating affordability of and access to essential psychological services for patients with mental illness.**

Term of Reference (e)(iii)

While I am not fully aware of workforce shortages, I am concerned about the most appropriate use and funding of the workforce to meet the needs of those with mental illness. I do know patients who have had severe difficulties regarding pharmaceutical medications who are unable to access any Psychiatric services at all because there are few privately practicing Psychiatrists who are willing to bulk bill and the local public Psychiatric inpatient or outpatient system cannot be accessed. The stressed GPs and stressed patients cannot fully access a Psychiatrist when needed and have to rely on telephone based secondary consultations between the GP and the public system.

I also know of patients with looming psychotic episodes or suicidally severe depressive episodes who have to wait until they experience a full-blown episode to access inpatient or outpatient services. They cannot access the frequent daily support they need to prevent a full-blown episode. These patients are making every attempt to manage their chemically-mediated mental health conditions without the appropriate supports.

I would like to see better funding for and better use of Psychiatrists, Mental Health Nurses and Social Workers to adequately support those with mental illness when they are needing frequent daily and 'drop-in' support, especially when the patient is aware of looming episodes. I would like to see funding for community-based mental health clinics where patients can just drop-in and be seen quickly to prevent worsening scenarios that clog the public hospital emergency departments. At present, some of this workforce is competing for the Medicare funding for "focussed psychological strategies" appointments of 50 to 60 minutes duration and may be booked up weeks in advance, as are Psychologists. Where is the diversity of service in that situation?

One aspect of psychological therapy is as a training process to teach the patient greater self-awareness, ongoing self-monitoring skills, cognitive and behavioural management skills, and relapse prevention skills. It is very frustrating for those with mental illness to learn such skills, put them into practice and then to not be able to access other necessary services in order to prevent a serious relapse. There is a desperate need in the community for quick response teams to be easily accessed so that those with very serious mental illnesses, including schizophrenia, bipolar disorder and severe depression do not have to wait until their condition becomes extreme before being able to access a full mental health service team such as those found in our public hospital system. It is like asking the person with a severe infection such as meningitis to wait right up until they are about to die before they can access medical and pharmaceutical treatment.

I do ask the Committee to clarify the training, experience and purpose of the various professions in the mental health workforce and the appropriateness of the tasks they are being assigned to undertake with government funding. Let us stop confusing the medical, pharmaceutical, physical, societal and psychological needs of those with mental illness and start providing for all those needs with the appropriately trained workforce applying their specific skills to the specific area for which they are trained.