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AUSTRALIAN COLLEGE OF PSYCHOLOGICAL MEDICINE INC.

SUBMISSION TO THE SENATE SELECT COMMITTEE ON MENTAL HEALTH

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SUMMARY OF MAIN POINTS OF THIS SUBMISSION:

- Medical Practitioners, especially General Practitioners, are the major providers of mental health care in Australia.
- Complex mental health problems often require a multi-disciplinary approach.
- Many sufferers, especially of chronic and complex conditions, are socially disadvantaged and cannot afford to pay for private services.
- GPs who are highly trained and skilled in providing mental health care are markedly disadvantaged financially compared with less skilled GPs doing more 'usual' medical work, and this is a disincentive to continue to do that work.
- The BOiMHC Initiative has only addressed this situation in a very limited way and some highly skilled practitioners are excluded from accessing the specific item numbers because of an anomaly in accreditation. Furthermore, the 20 hours of training that is required for registration at Level 2 of the Initiative is far from adequate to equip GPs to manage the complex situations that confront them.
- The College is convinced that early intervention and multidisciplinary preventive and social interventions are essential to reduce the Nation's burden of mental ill-health in the future.

Australian College of Psychological Medicine: History and Current Status.

The Australian of Psychological Medicine (ACPsychMed) was incorporated as a national body in 1998 by and for medical practitioners who have a special interest in treating psychological and psychiatric disorders and maintaining the mental well-being of their patients. The primary goals of the College are to provide peer support and educational resources for our member whilst also lobbying for improved primary mental health care services for both patients and practitioners.

The College consists of members in all states and territories of Australia. The majority are General Medical Practitioners. All of our Fellows and most of our members provide a significant proportion of their services in the area of mental health. The College has members across the spectrum of medical practice: in urban and rural practices; in solo general practice, large groups and hospital practice; in general practices that are both accredited and non-accredited; in public and private contexts and in many sub-speciality areas from adolescent mental health and eating disorders to pain management, addiction and psycho-geriatrics. The members of the College are not limited to psychiatric diagnoses but are vitally interested in psychosocial problems such as faulty parenting, child abuse, domestic violence and drug abuse, those things which so often although not exclusively are the results of social disadvantage and which can cause or exacerbate disabilities of many types.

Fellowship of the ACPsychMed has been approved as a registrable qualification by the SA Medical Board. Members achieve Fellowship by completing accredited, externally provided training programs and successfully completing the College's own Summative Assessment Process.

In partnership with the University of Adelaide's Department of General Practice the College conducts a course accepted as suitable training for registration at both levels of the Better Outcomes in Mental Health Initiative. It also provided a very comprehensive course in Hypnosis acceptable for similar registration until the Better Outcomes Implementation Advisory Committee withdrew approval for hypnosis as an appropriate Focussed Psychological Strategy in 2004.

Other educational partnerships have been established including with the Black Dog Institute in NSW and with a number of General Practice Divisions.

The College is a full member of the Mental Health Council of Australia. It is represented on the National Reference Group investigating ways of improving involvement of general practitioners in Promotion, Prevention and Early Intervention in Primary Mental Health, in conjunction with Auseinet and Australian Divisions of General Practice. It also participates on the Professional Peer Support Group Committee.

Many members of the College are regarded as leaders in the field. College members and fellows have been prominent in their representation on committees, projects and programmes of Divisions of General Practice since the inception of such divisions, work closely with the Royal Australian College of General Practitioners, including having a number working as examiners for that College's Fellowship examination and are actively involved in the Rural Doctors Association of Australia.

ACPsychMed is recognised as a respected and valuable organisation in Primary Mental Health Care. While we endorse the submissions made by RACGP and Divisions, as far as we understand their content, the Australian College of Psychological Medicine is ideally placed to provide an overview of mental health services in Australia, especially at the primary care level, and to recommend ways in which these services could be improved.

Submission of Australian College of Psychological Medicine with reference to the sections of the Terms of Reference that are particularly relevant to this College and its membership.

a. the extent to which the National Mental Health Strategy, the resources committed to it and the division of responsibility for policy and funding between all levels of government have achieved its aims and objectives, and the barriers to progress;

While the Strategy has produced many improvements, only some of which are sustainable, divisions of responsibility, especially between Federal and State governments, still impede progress.

After quoting Christopher Pyne who stated: "Australia's states and territories stand condemned for their failure to deliver adequate mental health services," Professor Gavin Andrews has stated that "Part of this rhetoric should be viewed in the light of federal-state relationships". "However", he adds that it "does reflect the uncoordinated way we fund our health systems - Medicare and Pharmaceutical Benefits at the federal level, private health insurance, the state and territory provisions of public-sector services and rising out-of-pocket expenses at the individual level. A co-ordinated funding system would be preferable" (1).

The Australian Bureau of Statistics, in 1997 survey, found that 18% of the Australian population met the criteria for mental health disorder or substance abuse in a 12 month period. Only 38% of those meeting the criteria received help from a health professional, and general practitioners delivered most care (2). In 2000, the Australian Burden of Disease Study showed that the largest mental disorder burden was attributable to anxiety disorders, mood disorders and substance abuse (3).

In 2004, a report by the Australian Institute of Health and Welfare on Mental Health Services showed that general practitioners deliver over 10 million mental health-related consultations annually (4). The importance of general practitioner involvement has not been fully recognised by governments and agencies.

General practitioners are paid largely by the Medicare system, with some funding from Divisions of General Practice, both of these being Federal Government responsibilities. Public primary mental health outpatient facilities are mainly State funded, with a significant contribution from Non-Government Organisations. Many sufferers from significant mental health disorders require a multi-disciplinary approach, with the majority of them too socially disadvantaged to afford private health insurance. This has made it difficult for general practitioners and state mental health professionals to co-ordinate service delivery, and there has been considerable mutual distrust based partly on systemically imposed limitations which is only slowly being broken down.

This must change. The two should be funded to work together more efficiently, learning to understand and respect each other where it most matters. This has happened patchily when individuals from both areas have instigated various projects, but it must become implemented policy.

There are a number of difficulties in the provision of mental health services by professionals of different disciplines.

- *Private psychiatrists* are largely inaccessible. Although valiant efforts are being made to involve them in a new item number under the BOiMHI banner [which facilitates assessment and advice at a minimal level only, providing little or no room for ongoing cooperative care], there appears to be no plan to extend this to provision of long-term care. This College would strongly support such an extension.
- There are many highly trained *psychologists* in Australia but many are unemployed or under-employed, because so many patients, especially the most medically needy, cannot afford to pay for their services, which in general are not funded by Medicare. Limited use is being made of them by a separate item number in BOiMHI, (see below) and this number is proving very popular but difficult to access with the requirement for having EPC planning in place prior to referral.
- *Public psychiatrists* are too few and are under-funded. Most are too busy coping with acute crises to be able to become pro-active in prevention and early intervention. Most have no time to deal with the high prevalence

disorders such as anxiety, depression, personality disorders and drug abuse, in the main treating the individually very demanding schizo-affective range of disorders. If we look toward the future and the mental well-being of the next generation we cannot afford to ignore the need to provide ongoing support services to those suffering from the kind of disorders with which the public system has no time to deal.

- *General practitioners* therefore have to provide a large proportion of mental health services in this country. It cannot be overemphasised that the mental health services General Practitioners provide are to the most financially needy, those who cannot access the private sector, and those with the most difficult diagnoses in terms of their social impact – those with chronic as opposed to acute problems who therefore cannot access the crisis-focussed public system either.

Members of the College are included amongst the many dedicated general practitioners who already deliver quality mental health care despite working in a system that scarcely recognises, rewards or encourages their contribution. Many general practitioners are providing dedicated long-term treatment for patients who have a complex array of psychological and social needs. This is a time-consuming process for practitioners and is frequently undertaken to their own financial and personal detriment.

The disadvantage financially is evident if the Medicare Schedule Fee for standard (level B) consultations is compared with the fee for a level D consultation. Many consultations for patients with mental health problems require at least 40 minutes and often an hour or more. A general practitioner dealing with usual medical problems could normally see four or more patients in the time that they could consult with one patient with a mental health problem. The Medicare fees for four standard consultations total $123.40, or $143.80 if they are bulk-billed and the bonus $5.10 payment is applicable. This compares with only $86.20 for one level D consultation or $91.30 if the bonus is applicable. The discrepancy in financial reward for those general practitioners who are highly skilled in dealing with mental health problems is compounded by the additional cost for them to obtain the ongoing

training that they need to do their work well. While the BOiMHI item numbers redress this to some extent their use is limited and not always applicable.

The Better Outcomes In Mental Health Initiative (BOiMHI).

The introduction of the general practitioner Item Numbers associated with BOiMHI has generally been regarded as a positive first step for practitioners faced with an increasing number of patients requiring psychological evaluation and treatment. However, they imply that treating psychological disorders is simple and straightforward.

The number for the "3 step process," is applicable to assessment, the development of a management plan and outcome measurement. Within that framework, the items for "Focussed Psychological Strategies" allow for up to 6 consultations to be made to implement the management plan, and it can be extended, after further assessment, to a maximum of 12 consultations in any one year.

Feedback from members of ACPsychMed has drawn attention to these areas of concern:

Inadequate level of training for general practitioners to access the numbers.

The current training requirements for general practitioners to access the new numbers is regarded as alarmingly inadequate. Only 9 hours training are required for the 3 step process, 20 hours for Focussed Psychological Strategies. The College's view is that this training by itself, whilst valuable, will not help general practitioners deal with any other than very simple problems, certainly not those involving complex problems with their contributing factors and consequences.

Many of our members have completed post-graduate training in psychological medicine, and our Fellows have stringent ongoing education requirements to fulfil. Many have Masters Degrees in the area. However, they are no better remunerated than those with 20 hours training.

Both the community and practitioners would be better served if the required training for the BOiMHI Item numbers was performed at the undergraduate level, as we believe that all medical students should be equipped with at least this level of knowledge.

The College recommends that an extension of item numbers to recognise and reward those performing more complex services should be introduced as a matter of urgency. This should include item numbers for longer consultations, preferably up to two hours in duration, as exist for psychiatrists and for ongoing psychological care of patients with complex problems. Any new system of item numbers must be devised in close consultation with general practitioners who have suitable training, experience and skills in the area. Members of ACPsychMed would be an ideal resource to contribute to such a consultation process.

The need for some patients with complex problems to be seen much more frequently than the six or twelve sessions allowed under the Focussed Psychological Strategies item number.

While the ordinary Medicare benefit item numbers still apply to such patients, the practitioner seeing them is disadvantaged (as illustrated above). Such patients include those with substance abuse or alcohol problems, eating disorders, personality problems, complex trauma histories, somatisation, and complex treatment-resistant depression.

Accreditation/Registration issues.

At present it is necessary for a general practitioner to be working, physically, in an accredited practice to be eligible for registration for the BOiMHI item numbers. This provision excludes a large number of highly qualified practitioners from accessing the relevant item numbers including many Fellows of the ACPsychMed.

For a variety of cogent reasons these members do not fulfil this requirement. Some work in University departments; others have deliberately chosen to do the overtly psychological part of their consulting away from the hurly-burly of a general practice for a more relaxed and quieter environment where patient-confidentiality can be perceived by patients as being better protected.

This results in the absurd situation where, some of practitioners are registered in one site and not in another. As an example the College can cite a member of ACPsychMed executive who works in two accredited practices. In one, he uses a room which is part of the accredited practice. In the other, the consulting room which he rents is not physically part of the accredited practice - it is in the same

building but in a part designated as the Specialist centre. In that practice he cannot be registered for BOiMHC despite doing the same work and having the same qualifications (namely a Masters degree in Psychological Medicine and additional qualifications) in each setting!

b. the adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care;

The College would especially like to comment on Prevention and Early Intervention.

There are quite a number of studies highlighting the importance of prevention and early intervention in minimising severity and reducing the frequency of episodes of mental illness, not least in the work of Professor Patrick McGorry and EPIC (Early Psychosis Intervention Clinic, in Victoria).

No group is better placed to promote this than general practitioners. Yet, as Hickie et al state (5) " While young people often prefer general practitioners to other existing pathways, actual use of general practitioner services for mental health problems remains low, and general practitioner responses to young people underestimate their need for psychological assessment and intervention."

Almost 50% of people with mental health disorders are not recognised by their general practitioner as having a psychological problem (6). Most psychotic disorders commence before age 25, and there is commonly a delay of two or more years before first presentation for treatment (7). Delay in recognition is not limited to psychosis, however, but includes such potentially preventable problems as eating disorders and the behavioural problems (eg addiction, self harm, family dysfunction, child abuse) arising from personality dysfunction.

ACPsychMed. is working with Auseinet to develop programmes which will address these issues. This will involve creating education modules to teach more general practitioners to become involved in advancing their knowledge and heighten their index of suspicion for detection of early cases. It is our contention that there is also a need for specialist GPs to deliver preventative strategies and therapeutic interventions to support the work of early detection.

e. the extent to which unmet need in supported accommodation, employment, family and social support services, is a barrier to better mental health outcomes;

The College believes there is no choice but to develop a co-ordinated approach to providing services dealing with social disadvantage and isolation along with the provision of mental health services. Socially and economically deprived areas such as Macquarie Fields in Sydney's south west illustrate the nexus between social disadvantage and the vertical transmission of emotional and behavioural problems which become endemic in a deprived community over only a few generations. Again, General Practitioners see evidence of great need on a daily basis. Family and social support services are too overburdened to arrive in time to help prevent the development of severe psychological and life dysfunction and problems are passed down to and magnified in succeeding generations. Supportive intervention needs to occur much earlier to treat parental dysfunction, teach anger management, teach survival strategies that don't involve substances and self harm and above all, help parents manage their children in non-damaging ways. Without adequate early social support we will continue to simply follow along behind picking up the pieces. All this is only partly the province of the GP and their role could be expanded (were there adequate support appropriately trained GPs – and such GPs exist - could provide group or individual training in parenting skills, mindfulness meditation or life management skills, for example) but the responsibility belongs to the whole health, education and welfare community . The extent of the current problem is a sad reflection on the failure of the system as it exists. The College wholeheartedly supports the notion of a coordinated prevention strategy in mental health.

g. the role and adequacy of training and support for primary carers in the treatment, recovery and support of people with a mental illness;

Issues of training for primary care practitioners, especially general practitioners, are very important and dealt with under item b. above.

n. the current state of mental health research, the adequacy of its funding and the extent to which best practice is disseminated;

The College believes that mental health research, an under-funded enterprise compared with other health issues, is very important. It should be encouraged and funded adequately.

However it is important to note that it is often difficult to devise a suitable method of evaluation of mental health research. Much of the modern practice of medicine is deliberately "evidence-based" but obtaining the "evidence" in issues concerning mental health is often extremely difficult and may be impossible. There is very good evidence for some treatments in such conditions as phobias, other anxiety disorders, and simple depressions. However in many patients with mental health problems, very complex, whole-of-life disabilities are involved. In such complex situations it is difficult therefore institute a manualised treatment that can be applied and studied to obtain "evidence". It has often been recognised that the "therapeutic alliance" between a therapist and client/patient is vitally important, but also difficult to evaluate and 'measure'

It is important that 'deficiency of evidence' is not interpreted as 'evidence of deficiency' and informed research into various treatment modalities and programmes will in the long term produce valuable information.

In Summary:

In the absence of adequate provision for ongoing care of people with serious psychological and emotional disturbance, GPs are frequently left alone with the role of caring for them. Many GPs and medical specialists are inadequately trained to recognise mental health problems beyond simply anxiety and depression and are completely ill equipped to manage them. Better undergraduate training in psychological medicine is essential and needs to be provided at the level of expectation seen in the current training for BOiMHC. Provision then needs to be made for GPs to be trained to a higher level and a tiered system of reward established according to those levels of training. Appropriately qualified GPs need adequate financial rewards and also greater flexibility in the way they are permitted to provide services. This flexibility must apply to location of service provision (accredited versus non-accredited sites) and number of services provided but also in terms of the kind of services provided (eg group therapy and preventative initiatives.)

General Practitioners need support from psychiatric services in both the Private and Public sector. The training of a greater number of psychiatrists and their better distribution throughout the country would certainly help the appalling shortage of services that exists in the private sector in some areas. It may also ease the extraordinarily long waiting times patients need to endure for a non-urgent psychiatric referral. More importantly however the under-funded public sector needs a huge boost in terms of staffing levels in order for it to provide not just adequate acute crisis management but ongoing care for the chronically distressed.

Underpinning all that, a great deal more attention needs to be paid to areas of prevention in mental health. Many GPs are in a position to help in that regard with early diagnosis as well as identification of people at risk. Some GPs could also help, especially if there were a way in which they could be paid for their efforts through Medicare, in providing education and early intervention. However the responsibility for prevention is broad. It needs to include education, health and social welfare initiatives which must be co-ordinated rather than competitive and aimed not just at improving the health of current patients but at improving the future for their

children. The cost to the community of failing to initiate preventative strategies in this generation will be incalculable.

The Australian College of Psychological Medicine is pleased to have the opportunity to contribute to this discussion and would be happy to make any further contribution the Committee needs to complete its report. We sincerely hope that this report is a prelude to significant much-needed improvement in mental health care in Australia.

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