CHAPTER 6

ACCESS TO MENTAL HEALTH SERVICES

6.1 Access to mental health services was a key issue for the inquiry. This chapter deals with the role of mental health professionals, workforce training and shortages and their uneven geographical distribution, government initiatives intended to overcome these problems, barriers to utilising allied mental health workers and alternative models of primary health care.

Workforce issues

Psychiatrists

6.2 Psychiatrists are medical practitioners with a recognised specialist qualification in psychiatry.[1] They work in public hospitals, community mental health services, private hospitals, and in private practice. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) stressed the importance of their leadership role:

> Psychiatrists are uniquely placed to integrate aspects of biological health and illness, psychological issues and the individual's social context. They provide clinical leadership with many working in multidisciplinary team settings. Psychiatrists treat patients and work with the patient's general practitioner, other health care providers, families and carers of patients, and the general community.[2]

6.3 Access to psychiatrists is however very limited. The Australian College of Psychological Medicine (ACPM) submitted that private psychiatrists were largely inaccessible because few bulk-billed, most are located in metropolitan areas and too few psychiatrists are employed in the public sector. ACPM pointed out:

> Most [public psychiatrists] 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. [3]

6.4 The RANZCP itself said; 'There is clearly a discrepancy between the available psychiatric workforce and the mental health needs of the population'[4]. Dr Martin Nothling, a psychiatrist representing the Australian Medical Association (AMA), said this shortage translated into long waits for patients to see psychiatrists:

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1 Royal Australian and New Zealand College of Psychiatrists (RANZCP), *Submission 323*, p. 2.

2 *Submission 323*, p. 2.

3 Australian College of Psychological Medicine (ACPM), *Submission 411*, pp. 6–7.

4 *Submission 323*, p. 3.

> ...in many cases there can be delays of weeks or months before someone can be seen because psychiatrists are literally so busy. It is common talk at any psychiatry meeting you go to where you talk to colleagues—everyone is booked out. How can you keep seeing patients? You cannot. ... You just cannot keep adding on patients and working on into the night.[5]

6.5 Several witnesses commented that not many private psychiatrists bulk-billed, putting access beyond the financial reach of many.[6] Psychiatrist Professor Ian Hickie told the committee that the out-of-pocket costs of seeing a psychiatrist had risen by 49 percent since 1998.[7]

6.6 Difficulty in attracting young doctors to train as psychiatrists was identified as a serious problem. The AMA indicated that many psychiatric registrar training positions across the country are not filled by trainees:

> Psychiatrists are among the poorest paid of all medical specialties and it is not attracting sufficient new entrants which will show up in serious workforce shortages in later years.[8]

6.7 The Australian Medical Workforce Advisory Committee found that psychiatry was one of a minority of specialisations in which fewer people were training than had been recommended, and the only one showing a decline in numbers.[9] Dr Nothling told the committee how potential trainee psychiatrists were put off pursuing a career in the field:

> They go into these emergency rooms and they see how dysfunctional they are. If you have a patient who is psychotic, what do you do? It is extremely difficult. You spend a lot of time on telephones trying to find a bed somewhere. You cannot get them in. The treatment they need is in-patient facilities. They are not available. The emergency rooms get clogged up. The young doctors see all that and they start thinking, 'Would you want to be in this area?' That is a big problem. Many doctors who have said to me: 'Look, I wanted to be a psychiatrist,' said that once they started to see how the system was not working decided they would go elsewhere.[10]

6.8 Compounding the shortage of psychiatrists is their poor distribution geographically, with the majority concentrated in urban areas. The National Rural Health Alliance (NRHA) observed that at the general hospitals outside of major urban centres that must deal with mental health in-patients, there are few or no psychiatrists, and that less than 3 percent of psychiatrists or psychiatrists in training work outside

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5 Dr Martin Nothling, Federal Councillor, Australian Medical Association (AMA), *Committee Hansard*, 19 May 2005, p. 68.

6 See, for example, Dr Georgina Phillips, *Committee Hansard*, 6 July 2005, p. 10.

7 Professor Ian Hickie, *Committee Hansard*, 19 May 2005, p. 28.

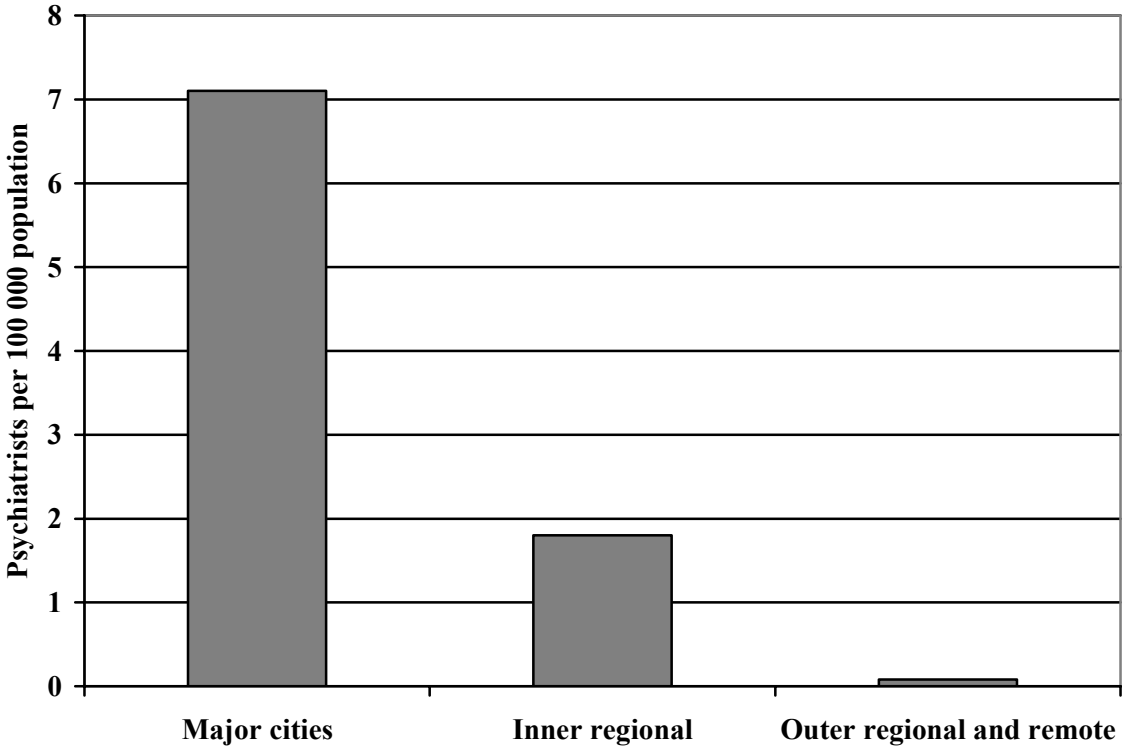
8 AMA, *Submission 167*, p. 2.

9 Australian Medical Workforce Advisory Committee, *Annual Report 2002–03*, AMWAC Report 2003.4, September 2003, pp. 15–19, http://www.health.nsw.gov.au/amwac/amwac/pdf/amwannual_20034.pdf, (accessed March 2006).

10 *Committee Hansard*, 19 May 2005, p. 64.

major cities and inner regional centres.[11] Data from the Australian Institute of Health and Welfare (AIHW) indicates that whereas there are 7.1 private psychiatrists per 100 000 population practising in major cities, the equivalent figure for non-major city areas is far less, with only 1.8 per 100 000 in inner regional areas, and less than 0.1 per 100 000 for outer regional and remote areas. (Figure 5.1)[12] Even within urban areas, psychiatrists are more likely to be located in more affluent neighbourhoods.[13]

Figure 5.1 Number of psychiatrists per 100 000 population



6.9 Lifestyle appears to be a factor in the maldistribution of psychiatrists. The RANZCP commented that psychiatrists liked to be close to fellow psychiatrists to share information and for continuing education programs.[14] Other evidence pointed to problems with practising in small communities:

> Unless you have a critical mass of psychiatrists on call ... you are going to meet most of your patients in Coles and your kids are going to be playing on the football team with some of your chronic patients et cetera. So there

11 National Rural Health Alliance (NRHA), *Submission 181*, p. 19.

12 Australian Institute of Health and Welfare (AIHW) 2005, *Mental Health Services in Australia 2002-03*, Canberra, AIHW (Mental Health Series No. 6), p. 199.

13 Ms Jane Halton, Secretary of the Department of Health and Ageing has indicated that ' there is a particularly high concentration of psychiatrists on the north shore of Sydney and east Melbourne.' *Estimates Hansard*, Senate Community Affairs Legislation Committee, 2 November 2005, p. 62.

14 Dr Julian Freidin, President, RANZCP, *Committee Hansard* 6 July 2005, p. 87.

> are issues about living in rural communities for mental health professionals generally that are tricky.[15]

6.10 Initiatives are being taken to address the lack of psychiatrists in rural and regional areas. These are discussed further in Chapter 16 in the context of the needs of rural and regional Australians.

6.11 The practice of psychiatry came in for criticism for its reliance on a medical model of treatment.[16] Some witnesses said psychiatrists assessed patients and formed a diagnosis too quickly and prescribed treatment that was all too often medication and/or confinement, They were also criticised for not treating the patient with respect and without taking into account the patient's perspective or broader needs.[17]

6.12 Mrs Pearl Bruhn, with personal experience of the mental health system, expressed frustration with the perfunctory treatment sometimes received:

> Psychiatrists, if you are lucky enough to see one, and not just a medical officer, spend only 15 minutes with each patient, with time only to discuss medication. There is no time to deal with the many other worries a patient is likely to have.[18]

6.13 Others complained:

> …psychiatrists knew that mania was a possible side effect of many anti-depressant drugs but they weren't apparently on the alert for it, and they apparently did not know how to recognise it, or what questions to ask. Even after I crashed, they had no idea how to deal with the aftermath, or how to deal with the devastation caused except to write more prescriptions.[19]

6.14 The Mental Health Foundation ACT was also critical:

> Professionals, especially medical people, still hold power and authority in our society. Psychiatrists are mainly educated in the medical model of prescribing medication, but are not necessarily clued into the importance of the relationship between themselves and their client, although this is changing.[20]

6.15 The pressure in public hospitals, and emergency departments in particular, contributed to what was seen as unsatisfactory psychiatric treatment:

> Many trainees are now forced to work on crowded, busy acute adult inpatient units, where the disorders are generally restricted to three or four diagnoses. The patients are chronic and almost impossible to treat and the focus is mainly on the biological therapies.[21]

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15 Dr Jennifer May, Secretary, NRHA, *Committee Hansard* 4 July 2005, p. 80.

16 See, for example, insane australia, *Submission 2* and attachments.

17 Dr Julie Johnstone, *Committee Hansard*, 5 August 2005, p. 18.

18 Mrs Pearl Bruhn, *Submission 147*, p. 2.

19 Name withheld, *Submission 449*, p. 4.

20 Mental Health Foundation ACT, *Submission 112*, p. 4.

21 Dr Anthony Llewellyn, in Health Services Union, *Submission 223*, p. 36.

6.16 Obviously not all consumer experiences with psychiatric treatment are negative. Consumer advocate, Mr John Olsen, a person with schizophrenia, described himself as 'one of the lucky ones' for whom medication worked. He told the committee of his gratitude to a psychiatrist (in a prison setting) who coerced him into taking medication, and established him on the road to a stable life.[22] Others referred to the positive experience of finding a 'wonderful psychiatrist' whose care greatly assisted them or family for whom they cared.[23]

6.17 The RANZCP responded to criticisms of psychiatry by saying that psychiatrists were working with a biopsychosocial model of care that was consumer-centred:

> In the clinical setting, the more information you can get about someone's social circumstances and social network and the involvement of their carers and their families and their own views, quite simply the better able you are to plan with them what needs to be done and then to implement a plan that will be successful and acceptable to them.[24]

6.18 Dr Freidin argued that inadequacies in psychiatric assessment and treatment are often the result of factors beyond the clinician's control, agreeing that sometimes this resulted in consumers and carers being marginalised:

> We are also aware, though, that practically, in stressed, under-resourced services, when people do start having to act fast to make decisions more quickly than ideally they should—for a host of reasons—one of the things that slips by the wayside is the time that should be taken to consult in detail with family and with the patient before deciding on an ongoing management plan. It is a little easier in private practice because one is a bit more able to control the pace of things.[25]

Mental health nurses

6.19 Mental health nurses work in public and private hospitals, community mental health centres and teams, prison mental health services, and in private medical practices. They are a significant part of the mental health workforce: in 2001 there were 62.2 mental health nurses per 100,000 population.[26]

6.20 A joint submission by peak nursing representative bodies, the Association for Australian Rural Nurses (AARN), the Australian and New Zealand College of Mental Health Nurses (ANZCMHN) and Royal College of Nursing Australia (RCNA), identified the current nation-wide shortage of psychiatric nurses as critical, and affected the ability of nurses to do their jobs properly:

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22 Mr John Olsen, *Committee Hansard*, 27 July 2005, pp. 59-60.

23 Name withheld, *Submission 131*, p.2.

24 Dr Julian Freidin, *Committee Hansard*, 6 July 2005, p. 90.

25 *Committee Hansard*, 6 July 2005, p. 90.

26 Australian Institute of Health and Welfare (AIHW) 2005, *Mental Health Services in Australia 2002-03*, Canberra, AIHW (Mental Health Series No. 6), p. 199.

> The mental health nurse may be so overburdened by their workload that they are unable to perform their roles to its fullest potential, and are themselves being exposed to stress and anxiety. Staff going on leave, especially in community services, are usually not replaced resulting in the remaining staff not having the time to follow up all of their clients.[27]

6.21 This joint submission from nursing peak bodies also pointed out that the workforce shortage is more marked in rural, regional and remote areas:

> There are a higher proportion of mental health nurses in the capital cities and very low numbers in smaller regional and remote areas (Australian Institute of Health and Welfare 2001). The shortage further compounds the under-servicing of rural and remote locations.[28]

6.22 The numbers of mental health nurses in major cities, inner and outer regional areas and remote and very remote are shown in Figure 5.2.[29]

Figure 5.2 Number of mental health nurses per 100 000 population

6.23 Submissions referred to the difficulty in recruiting and retaining nurses in the field of mental health. The ageing of this workforce was noted as a significant problem, with mental health nurse Mr Jon Chesterson observing that:

27 Australian Rural Nurses (AARN), the Australian and New Zealand College of Mental Health Nurses (ANZCMHN) and Royal College of Nursing Australia (RCNA), *Submission 321*, p. 5.

28 AARN, ANZCMHN and RCNA, *Submission 321*, p. 6.

29 Australian Institute of Health and Welfare (AIHW) 2005, *Mental Health Services in Australia 2002-03*, Canberra, AIHW (Mental Health Series No. 6), p. 11.

> ...the average age of the mental health nursing workforce is 47+, and more than half of the existing workforce is expected to retire within the next 15 years. The pitifully small trickle of new graduates into mental health today compared with the late nineteen seventies and early eighties has already resulted in a workforce crisis.[30]

6.24 The Health Services Union pointed out that the bulk of older nurses are graduates of the former direct entry psychiatric nursing courses.[31] Unlike their older colleagues, nurse trainees today must first undertake a three-year generalist nursing degree (with very limited content on mental health theory and clinical practice)[32], followed by post-graduate studies in mental health nursing. Thus there is a reliance on generalist graduates being attracted to pursuing further studies in mental health. The committee heard that this was not happening to a sufficient extent. The NSW Nurses' Association commented that 'the appeal of the sector to new graduates is diminishing.'[33] Stressful working conditions and significant levels of violence in the mental health workplace were mentioned in several submissions as negative factors.[34] The AMA commented:

> ...nurses are not being attracted to work in psychiatry because the system is dysfunctional and because of security problems. It is a common theme across the nation that nurses and doctors attending severely disturbed patients are being assaulted at a rate which is causing concern and public discussion amongst these groups.[35]

6.25 A study of a psychiatric unit at one hospital in NSW revealed high levels of violence and aggression, and pointed to the heavy toll on mental health nurses:

> [Psychiatric] Units where high levels of aggression and violent behaviour are experienced in the workplace on a daily basis must be acknowledged as dangerous workplaces. Staff work continuously under elevated stress levels (physical, mental and emotional). Staff locked in [these] units for eight hours per day for five shifts per week with aggressive patients must pay a toll in some way. [36]

6.26 To address the problems of recruitment, the joint submission from peak nursing bodies argued that mentoring in mental health nursing needed to be provided to encourage already practicing nurses into the field, and that funding incentives were also required:

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30 Mr Jon Chesterson, *Submission 177*, p. 3.

31 Dr Anthony Llewellyn, in Health Services Union, *Submission 223*, p. 14.

32 AARN, ANZCMHN and RCNA, *Submission 321*, p. 5.

33 NSW Nurses' Association, *Submission 391*, p. 7.

34 See, for example, *Submission 321*, p. 15; Mr Jon Chesterson, *Submission 177*, p. 6; AMA, *Submission 167*, p. 21.

35 *Submission 167*, p. 21.

36 James Fletcher Hospital Psychiatric Emergency Centre and Psychiatric Intensive Care Unit, *Overt Aggression Survey*, Mr M Witkowycz (RN), *Submission 349* (Attachment 1), p. 24.

> It is ... important that appropriate funding be made available for transition programs specifically for mental health ... for newly graduating nurses coming into the workforce, to attract them into this specialty field.[37]

6.27 The shortage of mental health nurses has been the subject of many reviews and studies. Submissions made reference to the 2003 report of the Australian Health Workforce Advisory Committee, *Australia Mental Health Nurse Supply, Recruitment and Retention*.[38] This report made a number of recommendations to address workforce shortage issues, including that an agreed framework for mental health content in undergraduate general nursing degrees be developed.[39] The committee notes the recent Victorian State Government *Victorian Taskforce on Nurses Preparation for Mental Health Work Report* (September 2005), which recommends, amongst other things, the trial of a specialist university degree with a major in mental health.[40]

Psychologists

6.28 The greater role that could be played by psychologists, particularly clinical psychologists, in Australia's mental health workforce was a strong theme in the inquiry.

6.29 Psychologists, as defined by the Australian Institute of Health and Welfare, consult with individuals and groups, assess psychological disorders, and administer programs of treatment.[41] They do not prescribe medication, and according to the Australian Psychological Society (APS), have spearheaded the development of non-pharmacological treatments.[42] There are several different specialisations within psychology, all requiring additional post-graduate study and training. The APS advised of a number of specialist affiliated colleges covering the fields of clinical, community, counselling, educational and developmental, organisational, neuropsychology, and health psychology.[43] The committee received evidence that psychologists can play an important role in the assessment and treatment of mental disorders.[44]

6.30 The public sector is a major employer of psychologists, particularly in community mental health teams. Yet evidence from representative psychologist bodies suggests that psychologists in these teams are increasingly employed in generic

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37 *Submission 321*, p. 5.

38 Australian Health Workforce Advisory Committee (2003), *Australian Mental Health Nurse Supply, Recruitment and Retention*, AHWAC Report 2003.2, Sydney.

39 Australian Health Workforce Advisory Committee (2003), *Australian Mental Health Nurse Supply, Recruitment and Retention*, AHWAC Report 2003.2, Sydney, p. 19.

40 Victorian Government Department of Human Services, *Victorian Taskforce on Nurses Preparation for Mental Health Work Report*, Melbourne, September 2005.

41 Australian Institute of Health and Welfare (AIHW), *Mental Health Services in Australia 2002-03*, Canberra, AIHW (Mental Health Series No. 6), 2005, p. 200.

42 Australian Psychological Society (APS), *Submission 50A*, p. 4.

43 *Submission 50A*, p. 4

44 Mr Raymond Rudd and Professor Henry Jackson, *Submission 401*, p. 4.

positions as 'case managers' or 'allied health workers', and not providing psychological assessment and treatment for which they are trained.[45] Many are too busy dealing with clients with serious mental illness to be able to provide effective early intervention 'upstream' treatment, or to provide treatment to those with high prevalence disorders such as depression. The Victorian Section of the APS explained:

> Mental health services are currently only available to those with the most severe mental health disorders. Many people suffering from complex and disabling psychological problems, including disorders of high prevalence, are unable to access psychological treatments in the public mental health sector, despite evidence of their effectiveness. In addition, the long waitlists and increasing caseloads present in continuing care mental health teams mean that little or no opportunity is available for clinical psychologists to provide early intervention and relapse prevention.[46]

6.31 Clinical Psychologist Dr Jillian Horton argued that public mental health services should maintain the capacity to provide psychological treatments by making more positions available for clinical psychologists:

> There needs to be many more positions available to six year trained Psychologists in Community Health Centres and public mental health services so that consumers can access these services. Psychological therapy positions should not be down graded into generic mental health worker positions or to other professions with short training in a limited number of psychological therapy skills.[47]

6.32 Better access to psychologists was not only supported for its potential to increase the scope of mental health services but also for helping to provide a better balance between 'drug-therapy' and 'talk therapy'. Some submissions expressed a view that medication as a treatment was sometimes overused by both psychiatrists and GPs, and that non-pharmacological treatment was often effective as an alternative or in combination with medication. The Western Australia Section of the College of Clinical Psychologists – APS - submitted that:

> Research from overseas indicates that most consumers with less serious mental health problems do not receive adequate care for their mental health problems from GPs and this can lead to a worsening of their mental health problems. Research also indicates that GPs tend to prescribe medication for less serious mental health problems which adds to the high cost of medical care, yet these individuals could be treated as effectively (and sometimes more effectively) by psychological interventions provided by clinical psychologists.[48]

6.33 Beyondblue argued:

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45 Victorian Section, APS, *Submission 479*, p. 4.

46 *Submission 479*, p. 3.

47 Dr Jillian Horton, *Submission 337*, p. 16.

48 Western Australia Section of the College of Clinical Psychologists – APS, *Submission 101*, p. 3.

> Non-pharmacological treatments, such as cognitive behaviour therapy, are effective and therefore need to be more accessible to the general community through improved access to psychologists and allied health.[49]

6.34 Access to psychological services was perhaps the single biggest issue about which the committee heard evidence. In the private sector, many psychologists registered to practise offer a range of psychological treatment for mental health problems. However, as many submissions pointed out, access to these private-sector services was beyond the financial reach of many. The cost of a one hour sessions with a psychologist usually ranges from $100 to $175[50] for which there is no Medicare rebate, unlike consultations with private GPs and psychiatrists. The Mental Health Association of NSW pointed out that 'people with depression often want a choice between medication and counselling, but find that their only access to counselling is through private practitioners, and Medicare does not cover these services'.[51] The Public Health Association of Australia commented that:

> ...for most people with mental disorders, clinical psychologists in private practice are only accessible to those with the ability to pay. This is therefore a greatly under-utilised resource, particularly as many of the newer psychological treatments are provided by this group of mental health professionals.[52]

6.35 This issue of whether or not governments should fund or subsidise access to psychological treatment in the private sector, either through Medicare or in some other way, was a recurrent theme of the inquiry. This matter is discussed in more detail in a later section of this chapter.

6.36 The committee notes that private health insurance (ancillaries cover) can provide some reimbursement of costs for psychological services, but the benefits paid cover only a small portion of the cost paid for the service[53] and many people needing mental health services are socially and financially disadvantaged, and cannot afford private health insurance.[54]

General practitioners

6.37 GPs are the first point of professional contact for a great majority of people seeking help with mental health problems.[55] Although research suggests that only 38

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49 Beyondblue, *Submission 363*, p. 2.

50 Black Dog Institute; Black Dog Institute fact sheets, available at http://www.blackdogInstitute.org.au/gettInghelp/consultprof/psychologIsts.cfm , (accessed December 2005). See also Anxiety and Depression Support Group Albury Wodonga, *Submission 151*.

51 Mental Health Association NSW, *Submission 230*, p. 12.

52 Public Health Association of Australia, *Submission 212*, p. 3.

53 Victorian Section, APS, *Submission 479*, p. 4.

54 Private health Insurance for Psychiatric Services is discussed in more detail in Chapter 12.

55 See, for example, General Practice Mental Health Standards Collaboration (GPMHSC), *Submission 320*, p. 3; Australian Divisions of General Practice (ADGP), *Submission 308*, p. 10.

per cent of those with mental health problems seek help, of those that do, 75 per cent do so in the first instance from a GP.[56] Many with chronic physical conditions visiting GPs frequently also have comorbid mental health conditions such as depression and anxiety.[57] The role of GPs in mental health is especially significant in rural and remote areas, where there are often no other health workers.[58]

6.38 Dr Rob Walters of the Australian Divisions of General Practice (ADGP) told the committee that 'it is general practice and not the specialist mental health system that delivers the greater majority of mental health care in this country', with over 10 million general practice visits in 2003-04 related to mental health.[59] Most people with high prevalence disorders such as depression and anxiety are seen by GPs.

6.39 The role of GPs as a 'gateway' to other services was mentioned in a number of submissions.[60] The AMA submitted that:

> General Practitioners (GPs) are the most accessible medical resource in the community and are the gatekeepers to other community resources such as specialist psychiatric care and acute care.[61]

6.40 The ACPM argued that, because of the limited access to psychiatrists and psychologists, GPs were significant providers of mental health care, especially to the financially disadvantaged:

> General practitioners ... 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.[62]

6.41 GPs should not be regarded as the last resort in service provision. The AMA argued:

> [It is necessary to] Recognise that GPs will not be able to 'pick up the pieces' when other mental health services, public specialist mental health services in particular, are not able to provide sufficient services to their consumers, particularly those with supposedly less serious mental illnesses and those in extreme disadvantage, including financial disadvantage.[63]

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56 AMA, *Submission 167*, p. 9.

57 *Submission 308*, p. 10.

58 SA Divisions of General Practice, *Submission 88*, p. 1.

59 Dr Rob Walters, Chairman, ADGP, *Committee Hansard*, 4 July 2005, pp. 82–83.

60 See, for example, Royal Australian College of General Practitioners (RACGP), *Submission 311*, p. 5.

61 AMA, *Submission 167*, p. 9.

62 ACPM, *Submission 411*, p. 7.

63 *Submission 167*, p. 41.

6.42 In recognition of the reliance on GPs for the provision of primary mental health care, the Australian Government in 2001 introduced and funded the Better Outcomes in Mental Health Care initiative (Better Outcomes). Better Outcomes provided education and training for GPs in mental health, improved access to psychiatrist support for GPs, and funded referrals to psychological services in private practice. Evidence to the inquiry indicates that Better Outcomes has been a useful initiative, though take-up by GPs and caps have limited its distribution. Better Outcomes is discussed in more detail later in this chapter.

6.43 The Inquiry into the Human Rights of People with Mental Illness in 1993 (the Burdekin Inquiry) had found that the training of GPs in mental health was inadequate, and that they often failed to identify mental illness.[64] The inquiry recommended that GPs receive more comprehensive mental health education.[65] One of the results of Better Outcomes has been an improvement in the mental health care skills amongst the approximately 20 per cent of GPs who have undertaken training. Several submissions argued that curricula at the undergraduate level and in GP registrar training were deficient in mental health assessment skills and care.[66] The ADGP suggested that the training provided in Better Outcomes should be incorporated into GP registrar training.[67]

6.44 It was argued that the general practice fee structure for Medicare rebates discouraged the long consultations often required when dealing with patients with mental health problems.[68] The Royal Australian College of General Practitioners (RACGP) submitted that more effective and comprehensive care was achieved within longer consultations, yet the GP consultation item structure encourages shorter consultations.[69] Evidence from the ACPM indicated that a GP dealing with usual medical problems could normally see four or more patients in the same time that they could consult with one patient with a mental health problem.[70]

Other professional groups

6.45 Social workers and occupational therapists are often members of community mental health teams, performing case-worker and other roles. However, the committee received little evidence regarding these professional groups. Training courses for a

64 Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness: Report of the National Inquiry Into the Human Rights of People with Mental Illness*, AGPS, Canberra, 1993, pp. 194–195.

65 Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness: Report of the National Inquiry Into the Human Rights of People with Mental Illness*, AGPS, Canberra, 1993, pp. 194–195.

66 See, for example, see GPMHS, *Submission 320*, p. 6.

67 ADGP, *Submission 308*, p. 3.

68 See, for example, AMA, *Submission 167*, p. 41; RACGP, *Submission 311*, p. 5; ACPM, *Submission 411*, p. 7.

69 *Submission 311*, p. 5.

70 *Submission 411*, p. 7.

relatively new group – Aboriginal mental health workers – is addressed in Chapter 16 in discussion of the needs of Indigenous people.

6.46 A submission from Psychotherapy and Counselling Federation of Australia (PACFA) argued that the counsellors and psychotherapists they represented (different from psychologists) were under-utilised in the mental health field:[71]

> Counsellors and psychotherapists are unique within the mental health field with respect to undertaking in-depth training, usually at a post-graduate level, in counselling and psychotherapeutic theory and skills, as well as their mandatory requirements for ongoing clinical supervision for the duration of the therapist's career.[72]

6.47 PACFA argued that PACFA-registered practitioners should be granted the GST-exempt status applied to psychologists and GPs, and should be included in Better Outcomes. Such inclusion, PACFA argued, would 'provide a much needed addition to the severely stretched mental health system and provide greater consumer choice, and better mental health outcomes.'[73]

6.48 There are also non-health professionals who, in the course of their work regularly encounter people with mental health problems. Teachers are often the first to identify mental health problems in young people; police officers are often relied upon to transport people with mental illness to hospital; government agency employees deal with people affected by mental illness; and family members are usually integral in care arrangements.

6.49 The Burdekin Report in 1993 recommended mental health training for a broad range of professionals in the community and Mental Health First Aid training is now available, increasing knowledge, reducing stigma, encouraging supportive responses and assisting with early intervention and the ongoing support of people with mental illnesses.[74]

6.50 Professor Tony Jorm and Ms Betty Kitchener (the originator of the Mental Health First Aid course), put the case that the course has been proved to be effective, and recommended Australian Government funding to support and train a national cohort of instructors:

> Once these are trained, the program can be self-supporting just like conventional first aid courses. For example, to train 100 additional instructors and to provide seeding support for them would cost around $400,000. These instructors would then train people who are outside the mental health sector, but have an increased probability of contact with mental health issues. These groups include teachers, nurses, welfare workers and family carers.[75]

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71 Psychotherapy and Counselling Federation of Australia (PACFA), *Submission 383*, p. 3.

72 *Submission 383*, p. 5.

73 *Submission 383*, p. 4.

74 Professor Anthony Jorm and Ms Betty Kitchener, *Submission 47*, p. 1.

75 *Submission 47*, p. 6.

6.51 The committee supports the idea of training in mental health for the wider community, and notes that Mental Health First Aid training can not only assist professionals such as teachers and police, but can also reduce stigma in the community, as a result of the greater general awareness of mental health issues in the community that results. The committee heard, for example, about the provision of mental health support training for hairdressers in Horsham, Victoria[76] – an excellent example of a group who talk to a lot people in their community and who could thus benefit from mental health first aid knowledge.

Initiatives that can improve access to better mental health care

6.52 In recognition of the need to increase the mental health skills of the existing GP workforce, and the need to improve access to mental health and allied health professionals, a number of initiatives have been developed in recent years. This section of the chapter looks at these initiatives, and discusses their achievements as well as some criticisms that have been levelled. In particular, this section examines the following initiatives:

- Better Outcomes in Mental Health;
- Chronic Disease Management Medicare items; and
- More Allied Health Services program.

Better Outcomes in Mental Health

6.53 The stated aim of the Better Outcomes initiative was 'the achievement of better outcomes for people with mental health problems by: providing GPs with training; introducing incentives to GPs for delivering structured, quality care; and enabling access by GPs and consumers to allied health professionals and psychiatrists.'[77] The initiative has been funded by the Australian government since 2001-2002 and has five related components:

- education and training for general practitioners to familiarise them with the initiative and to increase their mental health care skills and knowledge;
- 3 Step Mental Health Process which rewards best practice mental health care by general practitioners by providing remuneration for assessment, care planning and review of consumers with mental health problems;
- increased remuneration to general practitioners for the extra time they spend with mental health consumers providing focused psychological strategies;
- access to allied psychological services to enable general practitioners registered with the initiative to access focused psychological strategies for their consumers from allied health professionals; and
- access to psychiatrist support for GPs by providing remuneration to psychiatrists who participate in case conferencing with other health providers, and who provide mental health consumer management advice via the GP Psych Support service.[78]

76 Mr Gordon Gregory, Executive Director, NRHA, *Committee Hansard*, 4 July 2005, p. 71; Ms Brianna Casey, Senior Policy Manager, NSW Farmers Association, *Committee Hansard*, 2 August 2005, p. 16.

77 Australian Government, *Submission 476*, p. 33.

78 *Submission 476*, p. 33.

6.54 The training component involves two levels:

- Level One skills based training in managing mental health disorders in general practice (six hours of training), and
- Level Two training in extending skills in psychological treatment such as counselling and therapy (20 hours of training). These psychological treatments are known as Focussed Psychological Strategies (FPS) under the Better Outcomes, and include treatments which are evidence-based. That is, there is evidence to prove their effectiveness. Specific psychological treatments included are cognitive behaviour therapy, interpersonal therapy, and psycho-social education.

6.55 Once trained and credentialed, a GP can deliver these treatments as claimable items under the Medical Benefits Schedule (MBS). The specific MBS item numbers allow greater remuneration for the longer time spent in consultation, such as for consultations over 40 minutes that are used to provide focussed psychological strategies.[79]

6.56 In the 3-step Mental Health Process GPs make a patient assessment, devise a care plan, and review progress. On completion, GPs are entitled to a Service Incentive Payment (SIP) of $150. The GP Psych Support service operates nationally 'to provide all general practitioners with telephone, facsimile and email access to quality consumer management advice from psychiatrists, within a 24 hour timeframe, seven days a week'.[80] Also under this component, psychiatrists are remunerated for case conferencing with GPs.

6.57 The component of Better Outcomes which attracted the most comment during the course of the inquiry was Access to Allied Health Services, which allows GPs who have completed Level One training to refer a patient to allied health professionals under arrangements whereby the out-of-pocket cost to the patient is nil or is a small co-payment, usually less than $10. The great majority of referrals have been to psychologists, although the eligible professional groups include social workers, mental health nurses, and occupational therapists.[81] Referrals in the first instance are for six visits, with an additional six visits allowed subject to a review by the GP.

6.58 The Australian Government funds the Access to Allied Health Services through Divisions of General Practice around Australia, who then make their own funding arrangements with allied health services. Most commonly this is either by individual contract, or by direct employment.[82] In Round 1 of the pilot stage of the program, 15 Divisions received funding for Access to Allied Health Services projects.

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79 Medicare Benefits Schedule Item 2725.

80 *Submission 476*, p. 34.

81 *Evaluating the Access to Allied Health Services component of the Better Outcomes in Mental Health Initiative; Fourth Interim Evaluation Report*, Program Evaluation Unit, The University of Melbourne, April 2005, p. 11.

82 *Evaluating the Access to Allied Health Services component of the Better Outcomes in Mental Health Initiative; Fourth Interim Evaluation Report*, Program Evaluation Unit, The University of Melbourne, April 2005, p. 10.

In 2005 over 100 of Australia's 118 Divisions took up the initiative and receive funding.[83]

6.59 Uptake by GPs in the three years since the program began has, according to the ADGP, far exceeded initial predictions of GP interest,[84] if not government projections. Data indicates that 20 percent (one in five) GPs had completed training and registered.[85]

6.60 The ADGP submitted that:

> The allied health component has been a particular drawcard for GPs who have found that better access to allied health support has resulted in improved clinical outcomes for patients and improved management in the primary care setting.[86]
>
> Of all the measures funded by the federal government under recent national mental health plans, Better Outcomes has been a relative policy success, a success that has been consistently supported by all national mental health stakeholders...[87]

6.61 Local evaluation reports compiled through ADGP showed that participating GPs, allied health professionals and consumers were 'very satisfied' with the evolution of services through Better Outcomes.[88] ADGP commented that the nation-wide Divisions of Practice have been instrumental in driving reforms and encouraging GPs to take up the initiative, and they have called for the capacity of the Divisions Network to be expanded to improve the delivery of mental health care to better meet community needs, including access to health care by key groups:[89]

> The network, which is already in place and funded, is a unique infrastructure and agent of change that can build and support GP led sustainable primary mental health care teams, support primary mental health care work force development, promote coordinated and integrated care by linking general practice with other systems, deliver quality primary mental health care services, deliver models of service delivery tailored to local contexts and reach rural and regional Australia.[90]

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83 *Evaluating the Access to Allied Health Services component of the Better Outcomes in Mental Health Initiative; Fourth Interim Evaluation Report*, Program Evaluation Unit, The University of Melbourne, April 2005, p. 2.

84 ADGP, *Submission 308*, p. 19.

85 Australian Government, *Submission 476*, p. 34; ADGP, *Submission 308*, p. 19; GPMHSC, *Submission 320*, p. 3.

86 *Submission 308*, p. 19.

87 *Submission 308*, p. 41.

88 *Submission 308,* p. 42.

89 ADGP, *Submission 308,* p. 45.

90 Dr Rob Walters, *Committee Hansard,* 4 July 2005, p. 84.

6.62 Concerns have been expressed about the limitations of Better Outcomes, including:

- Insufficient take-up by GPs;
- Difficulties for rural GPs in undertaking Better Outcomes training;
- The need for GP practices to be accredited;
- Adequacy of 20 hours training in psychological treatment;
- Lack of access to psychologists in rural and remote areas;
- Limits placed on the number of patients GPs can treat and refer;
- Conflict of interest in pharmaceutical companies funding training; and
- The need to remove disincentives for longer consultations by GPs.

Insufficient take-up by GPs

6.63 Despite the positive reaction by GPs, it is nevertheless the case that only one in five GPs has undertaken at least Level One training. Thus four in five GPs – often including those with the least expertise in mental health - are not eligible to refer patients to a psychologist under Better Outcomes.

6.64 It was suggested that the take-up so far was largely by those GPs who already had an interest in mental health, and saw registering with Better Outcomes as part of their continuing interest and professional development and that GPs whose interests lay outside of mental health would be unlikely to undertake the training. [91]

6.65 It certainly appears that the proportion of GPs credentialed under Better Outcomes is unlikely to rise. The Department of Health and Ageing indicated that 'the number of additional general practitioners (GPs) who will complete Level One training under the Better Outcomes in Mental Health Care Program is about 150 each quarter and the number of GPs who will complete Level Two training is about 50 per quarter'.[92] While 600 GPs are completing Level One training each year, this seems no higher than the annual rate of turnover in the profession. In 2004, 557 places were filled in the General Practice Training Program,[93] and in addition to these new entrants, some doctors are recruited directly into the system as general practitioners from overseas. Thus the rate at which doctors are being credentialed for Better Outcomes Level One is no greater than the rate at which new doctors are entering the system, while the rate of training at Level Two may mean that the proportion of doctors accessing this option will actually fall.

6.66 The paperwork in the 3-step process was cited as a disincentive to take-up and, in particular, GPs were frustrated with the 'red tape' and paperwork required to claim the Service Incentive Payment (SIP) of $150. In recognition of these concerns, changes were made by the government in May 2005, allowing the process to be completed in two consultations rather than three. Nevertheless, take-up by GPs has been less than expected, resulting in a reduction in the forward estimates for funds

91 Dr Carole Castles, *Committee Hansard*, 28 October 2005, p. 46.

92 Department of Health and Ageing, answer to question on notice, 2 November 2005.

93 Department of Health and Ageing, *General Practice in Australia 2004*, p. 292.

earmarked for SIPs of $85.4 million over four years.[94] The Department of Health and Ageing told estimates hearings that in addition to the revised 3-step process, other changes were being contemplated to try to improve the take-up and make the process easier to use[95] and said in its submission to this inquiry:

> ...more needs to be done, especially in terms of engaging more GPs to use the components available in the Better Outcomes initiative. In recognition of this the Australian Government has committed $228.5 million over four years from 2005- 09 in supporting GPs in their role as primary carers of people with mental illness.[96]

Difficulties for rural GPs in undertaking Better Outcomes training

6.67 A further barrier to take-up by GPs according to some submissions was the fact that it was difficult for GPs in rural and remote areas to take time away from their practices to attend training, often conducted in a city, as it could leave a town without any medical care. The South Australian Divisions of General Practice submitted that:

> The more remote Divisions report considerable difficulty accessing the required training for their GPs to participate in the [Better Outcomes] scheme... Training of GPs to do counselling themselves (Level 2 under [Better Outcomes]) is likewise difficult as it requires the GP to do 20 hours of training – not available in the country thereby necessitating the GP to leave their practice unattended for a number of days. With the lack of available locum coverage to backfill, and rural doctors required to provide after-hours emergency care, this may leave entire towns and regions without any medical care.[97]

6.68 The associated costs of travel, and of finding a locum, were also a disincentive for rural GPs:

> At present, there is no alternative for a rural or remotely located GP but to travel to a regional or major centre in order to undertake the entry point training for the Better Outcomes initiative (Level One or Two accredited training). The travel requirements impose a significantly greater burden on rural and remote GPs who often have difficulties finding and funding a locum GP to service their area during their absence, and of course incur substantial travel, accommodation and loss of income costs.[98]

6.69 The GPMHSC suggested that some accredited Level One Better Outcomes training packages could be adapted for online or distance delivery, but also recognised that face-to-face training was preferable. The GPMHSC recommended that there be

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94 Mr David Learmonth, First Assistant Secretary, Primary Care Division, Department of Health and Ageing, *Committee Hansard*, 7 October 2005, p. 69.

95 Mr D Learmonth, *Estimates Hansard*, Senate Community Affairs Legislation Committee, 2 November 2005, p. 55.

96 Australian Government, *Submission 476*, p. 34.

97 SA Divisions of General Practice, *Submission 88*, p. 9.

98 GPMHSC, *Submission 320*, p. 4.

financial support provided for rural GPs needing to travel to undertake training, and incentives for training providers to deliver training in non metropolitan areas.[99]

The need for GP practices to be accredited

6.70 Another barrier to GP take-up of Better Outcomes is the requirement that for a GP to be eligible for the Service Incentive Payment, the 3-step mental health process consultations must be provided from a practice participating in the Practice Improvement Program (PIP) or an accredited practice.[100] The ACPM pointed out that this requirement excludes qualified medical practitioners who for various reasons do not see patients at an accredited practice – for example they may work at a university medical centre. The requirement can also lead to anomalies:

> [The requirement can result] in the absurd situation where some practitioners are registered in one site and not in another. As an example the College can cite a member ... 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 [Better Outcomes] despite doing the same work and having the same qualifications (namely a Masters degree in Psychological Medicine and additional qualifications) in each setting![101]

6.71 The costs and resources associated with achieving accredited status were also a barrier for some practices. Fundamental reorganisation of practice structure could be necessary, which was a disincentive for many.[102] The Northern Territory Government said this was a particular issue for practices in the Northern Territory:

> While the Australian Government's 'Better Outcomes in Mental Health Care' initiative attempts to increase the capacity of GPs to provide mental health care, the success of this initiative in rural and remote areas of the NT has been marginal. Although a number of GP practices and Aboriginal controlled health services in the NT were initially accredited and accessed training, fewer practices are now making that commitment due to the costs associated with achieving the expected standards and the relative benefits for individual practices. The uptake rate in the NT has been confined to a small group of Darwin based GPs.[103]

6.72 The AMA and the ADGP pointed out that the practice accreditation requirement excluded many Aboriginal Medical Services and youth-specific services[104] yet these were some of the highest need populations in the community.[105]

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99 *Submission 320*, p. 4.

100 General Practice Mental Health Standards Collaboration, Level One General Practitioner Registration Form: Better Outcomes in Mental Health Care.

101 ACPM, *Submission 411*, p. 9.

102 Professor Ian Hickie, *Committee Hansard*, 28 October 2005, p. 86.

103 Northern Territory Government, *Submission 393*, p. 16.

104 AMA, *Submission 167*, p. 24.

The ADGP recommended exception criteria for GPs working outside accredited practices, particularly those working with these high need groups.[106]

6.73 It was also pointed out that Better Outcomes accreditation operates independently of other accreditation and professional development for GPs. RACGP suggested:

> At the moment the accreditation processes for mental health training are separate from the RACGP quality assurance and continuing professional development program. In the future it would make good sense to roll these into one so that GPs do not have separate accreditation for mental health and all their other areas of education. It makes sense to roll these into the one QA and CPD program.

6.74 The committee agrees, and hopes that such streamlining might encourage some more GPs to take up Better Outcomes accreditation.

Adequacy of 20 hours training in psychological treatment

6.75 A view strongly expressed to the committee was that the 20 hours of training comprising Level Two training was inadequate to equip GPs with the necessary skills to provide effective psychological treatment (Level Two training covers specific psychological treatments including cognitive behaviour therapy). Organisations representing psychologists were adamant that 20 hours of training could not be considered the equivalent of the many years of study and clinical supervision undertaken by psychologists in order to register to practise. The APS submitted that:

> The techniques that GPs are expected to master in 20 hours are components of those required of psychologists to be registered to practise. Psychologist's training for registration involves a four-year university degree in psychology, two years post-graduate study (usually a Masters degree) and at least one subsequent year of clinical supervision (at least six years training). We believe that twenty hours of instruction in psychological therapy techniques is not adequate training and does not meet appropriate professional standards for mastering the skills for effective psychological intervention.[107]

6.76 The Association for Counselling Psychologists commented that the 20-hour Level Two training for GPs has been seen by psychologists as the equivalent of allowing psychologists to undertake brief training in medicine in order to prescribe drugs,[108] and argued that the delivery of psychological interventions should be reserved to appropriately qualified licensed and experienced mental health specialists.[109]

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105 ADGP, *Submission 308*, p. 43.

106 *Submission 308*, p. 8.

107 APS, *Submission 50A*, p. 9.

108 Association for Counselling Psychologists, *Submission 452*, p. [5].

109 *Submission 452*, p. [1].

6.77 There was some evidence that GPs were not necessarily using the psychological treatment skills they had obtained under Level Two training, but preferred to refer patients on to psychologists. Professor Ian Hickie told the committee that the training often had the effect of making a GP more likely to refer on, rather than deliver the service him or herself:

> What you see is that those GPs who have undertaken further training actually make more referrals, not fewer referrals. There is a belief system, which I think is quite wrong, that if GPs get more access to these items themselves or further training they will not refer. All the research evidence shows the opposite. The better trained people are, the more aware they are of what they cannot do and the more aware they are of options and of what others can do.[110]

6.78 At December 2004, almost 2000 GPs had referred almost 13 000 consumers for focussed psychological care by allied health professionals, and almost 50 000 sessions of therapy had been received by consumers.[111] GP-provided focussed psychological strategies totalled over 33 500 for the period January 2003 to December 2004.[112]

6.79 A number of submissions commented that, with a shortage of GPs in Australia, it made sense to utilise the workforce of psychologists, rather than further burden the already overstretched GP workforce.[113] Dr Jillian Horton commented that the long consultations required to deliver psychological treatments were time-consuming for GPs, and encroached on their medical practice:

> There is already a shortage of GP hours for medical care, and consumers often complain about the difficulty in getting medical appointments. Why would the Federal Government wish to burden this sector further and make the hours for medical care even less available to the public, when there are clear alternatives? Wouldn't supporting a way to ease and re-direct the mental health burden from GPs make more sense?[114]

6.80 Psychologists argued that the Medicare item numbers used by GPs to deliver psychological treatments should also be available to six-year trained psychologists:

> Enabling psychologist access to the Medicare items for Focussed Psychological Strategies ... would ease the mental health burden through mobilisation of a significantly under-utilised trained psychology workforce.[115]

6.81 Whilst there appears to be general support across the health professions for the idea of making better use of psychologists in the provision of mental health care, there is some debate over how best to achieve this, whether it should be through direct

110 Professor Ian Hickie, *Committee Hansard* 28 October 2005, p. 94.

111 ADGP, *Submission 308*, p. 41.

112 *Submission 308*, p. 41.

113 See, for example, Association for Counselling Psychologists, *Submission 452*, p. [4].

114 Dr Jillian Horton, *Submission 337*, p. 13.

115 APS, *Submission 50A*, p. 10.

or indirect access to Medicare items by psychologists, or through some other method. This matter is discussed further in a later section of this chapter.

Lack of access to psychologists in rural and remote areas

6.82 A number of submissions pointed out that although GPs welcomed the Access to Allied Health, the program fell down when no suitable professionals were available. This problem was most pronounced in rural and remote areas.

6.83 The South Australian Divisions indicated that their more remote Divisions had considerable difficulty in attracting appropriately qualified and experienced personnel. [116] The ADGP observed:

> ...regional and rural Divisions face challenges such as attracting suitably credentialed allied health workers to their communities. This is often due to the availability of relatively short term (annual) employment contracts. Recruitment and retention challenges are compounded by Better Outcomes' current status as a lapsing program which means it is difficult for divisions to offer ongoing positions to allied health professionals and facilitate recruiting and retaining them in rural and regional centres.[117]

6.84 The South Australian Divisions suggested:

> Some requirement or enticement for allied health workers to do some rural service, either as a fly-in model, or for a limited period of time, would also be welcome to address the workforce difficulties.[118]

Limits placed on the number of patients GPs can treat and refer

6.85 The Better Outcomes framework imposes a cap on GPs and their use of the Medicare items, presumably to control the budgetary implications of the program. The cap limits GP's claims for individual services (completed 3-step processes) to $10 000 per year per GP, which is the equivalent of 67 mental health plans.[119]

6.86 Professor Hickie argued that the cap discouraged GP practices from undertaking the practice reorganisation needed to participate in the program:

> The biggest disappointment from a GP point of view is what we see as the cap on the number of services. The Commonwealth rejects this as an issue, but what you want here is fundamental practice reorganisation, for GPs to alter the way they work. In fact, if you say there will be a limit to the number of people whom any individual or practice can service then you get a fundamental disincentive. So there has not been the degree of GP practice reorganisation that we would have hoped for...[120]

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116 SA Divisions of General Practice, *Submission 88*, p. 9.

117 ADGP, *Submission 308*, p. 44.

118 *Submission 88*, p. 9.

119 'Money's too tight to mention', *Australian Doctor*, 19 October 2005, http://www.Australiandoctor.com.au/articles/46/0c037346.asp , (accessed November 2005).

120 Professor Ian Hickie, *Committee Hansard*, 28 October 2005, p. 86.

6.87 The government indicated that in 2004-05 only 17 GPs out of over 4 000 who are trained had reached the cap.[121]

6.88 This was however not the only cap within Better Outcomes that attracted criticism. Another cap limits the number of referrals GPs can make under Access to Allied Health Services by limiting funding within individual Divisions. The AMA submission expressed this concern:

> [The] counselling component is subject to capped funding and GPs are very limited in the numbers of services that they may refer patients to, some Divisions reporting that they can only refer 5 patients per annum.[122]

6.89 The ADGP argued that allied health services are popular with GPs, allied health providers and consumers, but that demand is far outstripping supply. The ADGP called for an increase in funding for allied health,[123] and pointed out the inconsistency:

> It is perverse that GPs belonging to Divisions who have worked hard to enrol a large number of GPs in the program are then penalised when the available allied health services are 'rationed' due to capped funds.[124]

Conflict of interest in pharmaceutical companies funding training

6.90 The committee was told that pharmaceutical companies are involved in funding for training in Focussed Psychological Strategies (FPS). The appropriateness of this was questioned:[125]

> The financial involvement of pharmaceutical companies in FPS training is also a matter of serious concern. ... Such involvement represents a grave conflict of interest that undermines the focus of FPS training.[126]

6.91 The concern originates in part from the tension that currently exists between professional groups and their different approaches to treatment, as well as an understandable concern about the motives of pharmaceutical companies in funding training in non-pharmaceutical treatment options.

The need to remove disincentives for longer consultations by GPs

6.92 While Better Outcomes attempted to address the financial disincentives to GPs for conducting the long consultations often necessary when caring for people with mental health problems, the ACPM argued that:

> While the [Better Outcomes] item numbers redress [the disincentive problem] to some extent their use is limited and not always applicable...

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121 Mr David Learmonth, *Committee Hansard*, 7 October 2005, p. 70.

122 AMA, *Submission 167*, p. 25.

123 *Submission 308*, p. 7; see also APS, *Submission 50A*, p. 10.

124 ADGP, *Submission 308*, pp. 43–44.

125 Dr Leanne Rowe, Councillor, RACGP, *Committee Hansard*, 28 October 2005, p. 51.

126 Association for Counselling Psychologists, *Submission 452*, p. [5].

> 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.[127]

6.93 The submission from bluevoices (the consumer body of beyondblue) recommended a further increase in the rebate for longer consultations:

> Beyondblue/blueVoices acknowledges the advances made in General Practice in the Better Outcomes in Mental Health Care Initiative, and recommends that in subsequent budget cycles, the level of rebate offered to General Practitioners offering high quality mental health services to consumers was increased even further. There must be a reduction in the incentive to reward doctors for the number of patients they see each hour, when it is widely accepted that the volume of patients seen does not equate to good health care.[128]

Multidisciplinary care planning, and Medicare items for chronic disease management

6.94 Historically, Medicare has only provided rebates for services delivered by doctors.[129] In recent years, however, the Australian Government has experimented (in a limited way) with broadening the rebate to services delivered by allied health professionals, such as psychologists, practice nurses, physiotherapists and podiatrists.

6.95 Under Chronic Disease Management (CDM) Medicare items, GPs can involve allied health professionals in the care planning of patients with chronic and complex care needs, including patients with mental health problems. The CDM items replaced (in July 2005) Medicare items for Enhanced Primary Care (EPC). Medicare rebates are available for a maximum of five allied health services per patient in a 12-month period, following referral from a GP. Allied health professionals eligible include psychologists, Aboriginal health workers, occupational therapists, physiotherapists, and podiatrists. An allied health professional must be registered with Medicare Australia to provide Medicare rebateable services. The allowable five visits per 12-month period can be to different allied health professionals, for example, two visits to a physiotherapist, and three visits to a psychologist. The Medicare rebate for any of these services is $44.85.

6.96 The Central Australian Aboriginal Congress, which provides health services to Indigenous Australians in Alice Springs, was positive about this initiative:

> The advent of ... multidisciplinary care plans have also enabled better coordination of team care arrangements for [patients with complex and comorbid conditions], especially the coordination of GP involvement with

127 ACPM, *Submission 411*, pp. 8–9.

128 Bluevoices, *Submission 259*, pp 22–23.

129 Mr Phillip Davies, Acting Secretary, Department of Health and Ageing, *Committee Hansard* 7 October 2005, p. 34.

> the necessary allied health professionals such as psychologists and other counsellors who provide holistic care to these patients.[130]

6.97 The NSW Nurses' Association also welcomed the initiative:

> The introduction of the new allied health items under Medicare is a great initiative which the Association supports and we look forward to working with the Government to ensure that people with mental illness benefit from greater access to skilled nursing interventions. We recommend that the Government examine more closely the role of the mental health nurse practitioner with a view to making the benefits and advantages of wider implementation more widely available to the public.[131]

6.98 However, the Medicare items for CDM are limited to patients with complex and chronic conditions. Further, although visits to allied health professionals are subsided through Medicare, the level of rebate is just $44.85, leaving a patient with high out-of-pocket costs after visiting, say, a psychologist, whose session can cost $100 - $175 per hour.[132] Mr Keith Wilson, Chair of the Mental Health Council of Australia, expressed this concern:

> The recently introduced mechanisms under the chronic disease management items ... cost a person up to an additional $50 or $60 out of pocket to see a psychologist. You might get a $45 rebate, but it will cost you over $100. ... I think that, worryingly, [this initiative] has still left a very large burden of out-of-pocket expenses on those who wish to access [psychology] services.[133]

6.99 For a person receiving care under a CDM care plan, the $44.85 Medicare rebate applies regardless of the type or cost of service provided. A session with a physiotherapist or podiatrist, for example, attracts the same $44.85 rebate, despite the fact that these sessions may take less time and cost less than that with a psychologist. The Department of Health and Ageing indicated that:

> [There has been] debate ... about the structure of the rebates in relation to how services are provided for; for example, something like psychology versus physiotherapy and the amount of time that is taken and the rebates which are available. Where that structure might go in the future is a matter that is being considered.[134]

6.100 Mr Wilson indicated a preference for psychologists to be, in the main, contracted directly and for out-of-pocket cost for consumers to be nil or very small:

> [The Chronic Disease Management Medicare items arrangement] is quite different to the system that the Council and most other professional groups

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130 Central Australian Aboriginal Congress, *Submission 486*, p. [7].

131 NSW Nurses' Association, *Submission 391*, p. 9.

132 Black Dog Institute; Black Dog Institute fact sheets, available at http://www.blackdoginstitute.org.au/gettinghelp/consultprof/psychologists.cfm , (accessed December 2005).

133 Mr Keith Wilson, Chair, MHCA, *Committee Hansard*, 28 October 2005, p. 93.

134 Mr David Learmonth, *Committee Hansard*, 7 October 2005, p. 35.

> have championed under Better Outcomes, which essentially involved no additional out-of-pocket expenses or a small co-payment.[135]

6.101 It is important to note that, unlike arrangements under Better Outcomes, GPs do not require any particular training to make referrals to psychologists under CDM arrangements.

6.102 Departmental officials advised that CDM items have been funded by transfer of a projected underspend against, primarily, the Service Incentive Payment (SIP):

> There was, going back over the history of the mental health Service Incentive Payments as part of the Better Outcomes program, an underspend against what we had anticipated the level of expenditure to be, without the capacity for particular precision in that process. Some of that projected underspend going forward ... has been transferred to the [Medical Benefits Scheme] to create the new chronic disease management items.[136]

6.103 Concern was expressed that this transfer shifted funds from mental health to the more general area of chronic disease. In response, departmental officials argued that chronic disease management comprised a strong element of mental health, including in all the major chronic disease categories of cancer, heart disease and strokes. Chief Medical Officer Professor John Horvath told the committee that 'mental health is ... an important component of the entire chronic disease spectrum'.[137]

More Allied Health Services

6.104 The More Allied Health Services (MAHS) program aims to 'improve the health of people living in rural areas through allied health care and local linkages between allied health care and general practice'.[138] As with Better Outcomes, the federal government funds Divisions of General Practice, which then administer and fund allied health services. Unlike Better Outcomes, MAHS can fund a range of allied health professionals, such as dieticians and audiologists, and not just mental health professionals.

6.105 The MAHS program funds 66 Divisions - those with at least five percent of their population living in rural areas - to provide clinical care by allied health providers.[139] Divisions can use direct employment by the Division, or engage allied health service professionals under contract. The guidelines indicate that services should be provided free of charge.[140]

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135 Mr Keith Wilson, *Committee Hansard*, 28 October 2005, p. 93.

136 Mr David Learmonth, *Committee Hansard*, 7 October 2005, p. 68.

137 Professor John Horvath, Chief Medical Officer, Department of Health and Ageing, *Committee Hansard*, 7 October 2005, p. 69.

138 Australian Government, Department of Health and Ageing, Guidelines for the *More Allied Health Services Program*, Divisions of General Practice Program, update as at July 2004, p. 8.

139 Australian Government, *Submission 476*, p. 36.

140 Australian Government, Department of Health and Ageing, Guidelines for the *More Allied Health Services Program*, Divisions of General Practice Program, update as at July 2004, p. 13.

6.106 The ADGP commented:

> While MAHS was not a mental health initiative, a great proportion of the eligible rural Divisions elected to devote it to the establishment of allied psychological services in their community.[141]

6.107 In 2003-2004, the MAHS program engaged 45.7 psychologists, 23.2 mental health nurses, 8.6 counsellors and 12.5 aboriginal mental health workers (full-time equivalents).[142] The Top End Division of General Practice in the Northern Territory has used MAHS funding to employ Aboriginal mental health workers.[143]

6.108 The Government guidelines for MAHS however discourage its use where Better Outcomes is available:

> If Divisions receive funding from multiple sources, they should use this funding effectively. For example, a Division could seek to consolidate their mental health services using Better Outcomes in Mental Health, leaving MAHS for other allied health professionals.[144]

6.109 However, not all GPs are registered with Better Outcomes and therefore cannot refer to psychologists. The Limestone Coast Division in South Australia (covering an area around Mount Gambier) found MAHS to be an important component of the mental health services available to GPs in that area[145] and MAHS, like CDM, allows GPs to refer patients to psychologists or other mental allied health professionals, without needing to have undertaken particular training, as is the case with Better Outcomes.

What is the best model for increasing access to cost-supported psychologists?

6.110 There was broad agreement that psychologists and other allied mental health professionals play an important role in primary mental health care, but that they are currently an under-utilised resource. Psychiatrist Professor Ian Hickie said:

> ...there is agreement across the whole medical and psychological health work force. All we need is an integrated work force. We need people to be working in partnership with each other, particularly at the primary care level and at the specialist level. We are different in Australia, in that we do

141 ADGP, *Submission 308*, p. 20.

142 Australian Government, *Submission 476*, Attachment 8.

143 Top End Division of General Practice website, http://www.tedgp.asn.au/resdoc/31stDecProgressReport.doc, (accessed December 2005).

144 Australian Government, Department of Health and Ageing, Guidelines for the *More Allied Health Services Program*, Divisions of General Practice Program, update as at July 2004, p. 5.

145 *Evaluation of the Better Outcomes in Mental Health and More Allied Health Services Initiatives*; Final Report; Limestone Coast Division of General Practice (LCDGP), June 2005, p. 1. Available at http://www.sesadgp.org.au/fIles/links/Mental_Health_Final_Report.pdf , (accessed December 2005).

> not recognise psychologists as mental health specialists in the way they are recognised in other systems, and we do not use them effectively.[146]

6.111 In the United Kingdom, the National Health Service (NHS) funds psychological therapy services, and patients can receive treatment on GP referral at no cost. Services are provided at GP's surgeries, hospitals, or local community mental health teams.[147] The committee also notes reports that the UK system has waiting lists of nine months to access counsellors. Nevertheless, there is significant recognition of the importance of psychological counselling services.

6.112 Mental health teams in Australia often include psychologists, but these staff are often have high work loads acting as case managers for people with serious mental illness, and do not have the time to provide psychological treatment, early intervention or relapse prevention strategies. Dr Georgina Phillips commented that in her experience on a community mental health team there were not enough counselling or therapy services available, and that it was difficult to find affordable alternatives:

> My experience was that we were constantly swamped with referrals for young people who had long-term issues that needed long-term therapies and we really struggled to appropriately refer them to something that was not going to be quite financially difficult for that person.[148]

6.113 Affordable access remains limited and many submissions supported expansion of the current Government initiatives. The following section discusses the issues involved.

Should GPs need particular training in order to refer patients to allied health professionals?

6.114 As previously discussed, GPs must have completed Level One training and stay registered with Better Outcomes in order to refer patients for low-cost psychological treatment through the Better Outcomes program. This requirement seems inconsistent with the other Government initiatives discussed above, which allow GPs to refer patients to cost-supported mental health allied professionals without any additional training or registration requirement.

6.115 More broadly, there also seems to be an inconsistency in the fact that, in the case of referrals to medical specialists such as cardiologists or psychiatrists, GPs do not require special additional post-graduate training. Presumably this is based on recognition that GPs receive enough basic training (in cardiology or psychiatry, say) in their undergraduate degree or GP registrar training to equip them to recognise a need for additional specialist care. It could be argued that the training received at the undergraduate level in psychiatry and psychology should similarly allow a GP to refer a patient to a psychologist, without a requirement for further training. It would appear that arrangements under the CDM care plans and also under the MAHS program

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146 Professor Ian Hickie, *Committee Hansard* 28 October 2005, pp 91–92.

147 Cambridgeshire Mental Health Info factsheet, available at http://www.cambsmentalhealthinfo.nhs.uk/support/talking_therapies.html, (accessed 1December 2005).

148 Dr Georgina Phillips, *Committee Hansard*, 6 July 2005, p. 10.

already accept this proposition; yet a GP referring under Better Outcomes needs additional training to make the same referral.

6.116 It was suggested to the committee that the Level One training requirement (which allows a GP to refer to a cost-supported psychologist) reflected the incentive nature of the Better Outcomes program, which aimed to reward GPs for undertaking training and up-skilling.[149] However, a result of this limitation on GPs is that patients are affected by their GP's willingness and ability to undertake the Better Outcomes training. The training requirement precludes the four out of five GPs who have not undertaken Better Outcomes training from referring patients. The patients of these GPs are clearly disadvantaged by this requirement.

6.117 Professor Harvey Whiteford, Clinical Mental Health Advisor to the Department of Health and Ageing, acknowledged this as an issue:

> You could take the position ... that the GPs who have less interest in mental health—do not bother to do the training—should be the ones who get better access to the psychologists who have the skills. I think the view that has prevailed is that we want to encourage all GPs to upskill and the quality of the referral to the psychologist is greater than the knowledge base of the GP. ... I have sympathy with [the] view that the patients of GPs who are not interested in mental health should in some way get support if they have mental health problems. As Mr Davies [Acting Departmental Secretary] said, there are some GPs who will not ever be interested in mental health. It is not their area and they do not like it particularly, but they may well have patients with those issues. I do not think this strategy necessarily helps them as much as those GPs who are more interested in mental health, so we needed to broaden the strategy as we work it through.[150]

6.118 The question thus arises of whether it is sound and reasonable to allow referral to cost-supported psychologists by *all* GPs. Professor Ian Hickie thought that the medical profession would be willing to allow referral to cost-supported psychologists by *all* GPs, not just those who had undertaken particular training. The problem, Professor Hickie suggested, was there not being sufficient government funding to cover that increased degree of psychological service and support.[151]

6.119 Professor Hickie further suggested that allowing GP referrals to appropriately qualified and recognised practising psychologists would quickly boost the mental health workforce:

> Fundamentally, this is an issue for the psychological profession itself. But if those who agreed to reach a certain standard of training behaved as mental health specialists, just the way that psychiatrists do, and then saw people essentially on GP referral then I think you would have absolute agreement between psychology and psychiatry.

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149 Professor Ian Hickie, *Committee Hansard*, 28 October 2005, p. 95.

150 Professor Harvey Whiteford, Clinical Mental Health Advisor, Department of Health and Ageing, *Committee Hansard*, 7 October 2005, p. 67.

151 Professor Ian Hickie, *Committee Hansard*, 28 October 2005, p. 95.

> ...
> If the Commonwealth were to immediately recognise the number of psychologists who would automatically meet that [standard of training]—there is some debate about that number but there would be somewhere around 2,000 psychologists—and they were to behave like the 2,000 psychiatrists we are working in practice, we would immediately double the mental health specialist work force, and it would not kill the Treasury.[152]

6.120 On the question of requiring a recognised system of qualifications and registration for practising psychologists, the committee notes that there is already government recognition of psychologists providing services through the CDM care planning Medicare items. These psychologists must be registered with Medicare Australia for their services to be rebateable.

If a system of referrals to cost-supported psychologists by ALL GPs is supported, should this be done through a Better Outcomes-type arrangement, or through Medicare?

6.121 As mentioned earlier, GPs currently have the ability to refer *some* patients for Medicare-rebateable treatment by a psychologist (under CDM Medicare items). This arrangement leaves patients with significant out-of-pocket costs, however, as the rebate of $44.85 falls short of the cost of a session with a psychologist, which usually exceeds $100. It is this concern about out-of-pocket costs which causes the MHCA to favour a system such as Better Outcomes, where consumers receive psychological treatment at no cost, or for a small co-payment.[153]

6.122 The APS supports an expansion of the arrangements under Better Outcomes for Access to Allied Health Services, to allow more GP referral for psychological services. At the same time, the Society also supports a Medicare-based arrangement, allowing psychologists access to the same Medicare item numbers for Focussed Psychological Strategies available to GPs who provide this service after having completed Level Two Better Outcomes training.[154]

6.123 The issue of expanding access to allied health professionals through Medicare has been raised in other forums. In 2003 the Senate Select Committee on Medicare considered suggestions of extending Medicare to cover allied health services, and acknowledged in its majority report that such action would have considerable and complex economic and financial consequences. A concern of that committee was that an extension of Medicare would raise the issue of which services would receive priority for Medicare funding and which would not qualify. It was also pointed out that decisions about extending coverage could arbitrarily create a financial windfall for certain professions while excluding others.[155]

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152 Professor Ian Hickie, *Committee Hansard*, 28 October 2005, pp. 94–95.

153 Mr Keith Wilson, *Committee Hansard*, 28 October 2005, p. 93.

154 APS, *Submission 50A*, p. 10.

155 Senate Select Committee on Medicare, First report, *Inquiry into Medicare: Medicare - healthcare or welfare*, October 2003, pp. 143–144.

6.124 The Select Committee on Medicare concluded that rather than extending Medicare coverage, it would be preferable instead to utilise more targeted and effective mechanisms to increase access to allied health professionals. The committee suggested building on existing initiatives such as the MAHS program, and providing funding for shared access to resources via groups such as the Divisions of General Practice.[156]

6.125 The issue of extending Medicare coverage to allied health professionals was also considered by the Productivity Commission in its position paper on 'Australia's Health Workforce', released in September 2005. The Productivity Commission expressed the view that existing mechanisms for assessing requests for changes to Medicare coverage lack transparency. It proposed the establishment of a single, broadly-based and independent body to make recommendations to government about extending Medicare coverage to new services.[157]

Should GPs remain the gateway for access to cost-supported psychological treatment, or should consumers have access without a GP referral?

6.126 A possibility raised with the committee was not only for the government to fund or subsidise psychological services (through Medicare or by some other method), but to allow consumers direct access to psychologists, without the need for a referral from a GP. It was argued that GPs are not necessarily appropriate to perform the role of 'gatekeeper':

> [The requirement for GP referral] ... means that GPs become solely responsible for the identification of psychological health problems, acting as gate keepers for psychological referrals, something which, for a range of reasons, GPs have a poor track record with.[158]

6.127 Professor Ian Hickie indicated that such a proposal had been contentious:

> ...some areas of psychology have argued that it should be the same as general practice, that somebody should be able to walk in off the street and see someone in a primary care role and receive their psychological care independently of any other aspect of the medical system. It is that model which has created much more contentious discussion, because it would be a more divided model, where psychological care and medical care would not necessarily come together. You would essentially have another primary care work force separated from the other work forces. So the issues of working together and immediately recognising those who obviously have the expertise—and the numbers vary, but there are 2,000 to 3,000 psychologists in Australia—would be a very effective, immediate solution to the specialist side of the problem.[159]

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156 Senate Select Committee on Medicare, First report, *Inquiry into Medicare: Medicare - healthcare or welfare*, October 2003, p. 144.

157 Productivity Commission 2005, *Australia's Health Workforce*, Position Paper, Canberra.

158 Dr Jillian Horton, *Submission 337*, p. 14.

159 Professor Ian Hickie, *Committee Hansard*, 28 October 2005, p. 94.

Concluding remarks

6.128 The committee considers that most people with mental illness do not currently have access to an integrated, specialised mental health service that meets their needs and that fixing the problems identified in this chapter is essential.

6.129 At the heart of the problems in primary care are three related issues:

- limited effective access to mental health workers;
- limited numbers of mental health professionals; and
- inadequate training of mental health professionals.

6.130 There are many ways in which each of these three things could be tackled. More direct involvement of psychologists in publicly-funded health care is one. More university places and more funded positions is a second. Stand-alone specialist degrees for mental health nurses is a third. Many of these solutions will take time and resources.

6.131 It is also clear that the current reliance on GPs for the bulk of those using primary mental health care and for prevention and early intervention is ineffective. Initiatives aimed at supporting GPs in this role have made some progress but relatively minor adjustments, such as removing the need for GPs to have undertaken Better Outcomes training as a pre-requisite for referring to allied health professionals or direct access to Medicare rebates for psychologists, fall well short of providing comprehensive, expert and timely care.

6.132 For greatest effectiveness, psychiatrists, psychologists, psychiatric nurses, social workers and GPs should work together in integrated teams. This does not seem possible under the current arrangements.

6.133 The committee is of the view that publicly funded community-based mental health centres should be established as the primary mental health equivalents of the tertiary area mental health services that currently operate in many states for the most seriously ill. These centres should be multi-disciplinary and treat the broadest range of disorders. GPs and psychiatrists in private practice who are interested and have expertise in mental health would continue to practise in this area but would have the support of the centre in doing so. Whilst funding the infrastructure and the training would require considerable investment, the committee considers that over time that investment would be rewarded with far less demand on acute care and our prison system and greater participation of people with mental illness in society.

6.134 A comprehensive shift toward multi-disciplinary community based mental health centres would help complete a shift away from acute hospital care, away from the old institutions (many of which continue to operate, particularly in South Australia and New South Wales), and toward the agreed goal of the National Mental Health Strategy: an emphasis on community based care. The need for this shift to be given a new impetus is starkly underlined by the findings in later chapters on inpatient, crisis and community care.

6.135 The committee believes that this shift can ably be supported by Divisions of General Practice, with their increased focus on multidisciplinary teams and the broader emphasis on primary care generally rather than just traditional general practice, as recommended by the Review of the Role of Divisions of General Practice, and endorsed in the Commonwealth's response to that review.[160]

160 Review of the Role of Divisions of General Practice, *The Future Role of the Divisions Network*, June 2003, http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pcd-programs-Divisions-divfuture.htm, (accessed March 2006); Commonwealth Government, *Divisions of General Practice: Future Directions. Government Response to the Report of the review of the role of Divisions of General Practice*, April 2004, http://www.health.gov.au/internet/wcms/publishIng.nsf/Content/health-pcd-programs-divisions-index.htm/$FILE/fut_dir.pdf, (accessed March 2006).