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I am a registered psychologist, working in a large private practice, who would like to express my concerns regarding the provision of mental health services, and to provide feedback on some of the shortfalls therein, and how these may be addressed in future models for public funding.

As a psychologist in private practice, my submission focuses on the experience of service delivery in a private psychology practice predominantly receiving referrals under the Better Access (Medicare) system.

Executive summary

Current models of funding and service delivery do not support best practice in the delivery of client services, for both individual and group therapies – resulting in poor outcomes for clients unable to access continued support (often for financial reasons) beyond the scope of services eligible for Medicare rebates.

The two-tiered system of Medicare rebates for psychological therapy represents a discrepancy in the allocation of public funding that has seen marked inequity of access to Medicare funded psychological services by members of the public accessing psychological treatment through Better Access.

Furthermore, the distinction between Focused Psychological Strategies (which covers what non-clinical psychologists can use with their clients) and Psychological Therapy Services (restricted to clinical psychologists only) further limits the care members of the public are able to access without any sound justification.

Public and community based mental health services lack continuity of care, often only consider extremely severe presentations as eligible, and are limited by insufficient beds available to meet demand.

Medicare Better Access

My first concern addresses the client access to Medicare funding. Primarily, the current rebate available is limited to only 10 sessions per calendar year, which is grossly inadequate. Best practice evidence suggests that twice this many sessions would be needed, more for complex presentations, to adequately address common concerns. This limited number places the public at risk of dropping out of treatment before completion – usually out of financial necessity, increasing the risk of relapse and need for further intervention in future (in my experience, usually the new calendar year when they are eligible for Medicare rebates again). I understand there is a major review of Medicare eligible items occurring at the moment, and have proposed that all clients accessing psychological care under Medicare be entitled to a minimum of 20 rebatable sessions per calendar year.

Furthermore, whilst the Medicare system has been established and argued to support only mild to moderate presenting mental health concerns, the lack of publicly available services (discussed further below) means that comorbid diagnoses and complex presentations such as personality disorders, schizophrenia and Post Traumatic Stress Disorder are commonly being referred to privately practicing psychologists under Medicare in the absence of adequate community based programmes and support. Best practice indicated for such presentations is weekly psychological and psychiatric treatment, usually within a multidisciplinary team also addressing the many biopsychosocial barriers experienced by sufferers of severe mental illness. The existing private system under Medicare (which is the predominant avenue to access service experienced by Australians) does not afford adequate time or resources to treat clients adequately in their individual care experiences or in a coordinated care approach. This places the Australian public at

significant risk of falling through the cracks, and places an unreasonable burden on existing supports – such as GPs and private psychologists, to be managing care and support for clients outside the scope of treatment – diminishing treatment effectiveness over time as each session spent managing these personal issues (such as financial hardship, difficulty navigating the Centrelink system, homelessness, domestic violence, the legal system, employment services and underemployment) detract from a focus on therapeutic interventions that will help the underlying issues.

It is also notable that personality disorders are not covered by Medicare, but for individuals suffering a personality disorder, comorbid diagnoses of depression or anxiety (for example) are incredibly common. These are treatable under Medicare, yet are rarely able to be sufficiently addressed or resolved given the complex presentation of such clients and the small number of sessions available.

Another area of some concerns is that of group treatment. Currently Medicare restricts client access to groups contingent upon a minimum of 6 people attending group treatment for a maximum of 60 minutes. The restrictions posed here place group members at risk – should not enough attendees arrive for any given session, the group cannot proceed, or group members are expected to pay full out of pocket expenses. Furthermore, it is nearly impossible to conduct adequate group treatment within a 60 minute timeframe, relegating treatment to didactic experiences and psychoeducation which do not allow clients to benefit from the many rich and diverse experiences that can be drawn from more intimate, interactive, sustained experiences. Consequently, a potentially very cost effective and therapeutically effective treatment modality is lost due to bureaucratic factors that make this treatment impossible to offer without significant risk of financial hardship to the clients and/or the provider of service.

Since 2006 Medicare has also offered a two-tiered rebate for clients to access psychology services in Australia, one rebate available for psychologists and another for psychologists with an Area of Practice Endorsement in Clinical Psychology. This model arose without due consultation with the wider community of psychologists and has been in dispute within the discipline itself since. My concerns regarding the two tiers are based on several contextual features that are difficult to ignore. Firstly, that no other allied health practice or discipline operate with more than a single tier under MBS billing for delivery of the same service. There is recognition within this that all registered practitioners are competent and able to practice, and that clients will choose their practitioner based on their skills, reputation and interest areas. As there is no evidence that outcomes achieved by either group of qualified professionals are any different, this is an extremely cost-ineffective practice and often results in client confusion and selection of practitioner based upon financial factors rather than the provider who may be best suited (have the best skills and experience) to address the client's presenting concerns.

I have supported removing the two-tier rebate system in favour of equality and a single Medicare rebate for psychological services in all consultations I have been invited to participate in (through the APS, the AAPi and the MBS review itself). I believe this change would facilitate patients' legitimate right to choose a psychologist based on a therapeutic needs-basis rather than choosing a psychologist based on the rebate available and financial constraints – a system which can only lead to risk of psychologists practicing outside their areas of competence (based on high demand for service related to rebate instead of skills, training and areas of practice interest), and lengthy waitlists for clients (two thirds of psychologists are not clinically endorsed, and therefore only able to claim the smaller rebate – these psychologists are less likely to bulk bill based on pure financial concern alone).

Medicare rebates themselves have been frozen now for psychological items since 2013. Psychologists themselves are increasingly unable to offer bulk billing to clients as costs increase without any corresponding increase in the rebate available through Medicare (preliminary

investigations estimate a fully bulk billing psychologist can expect to take home \$22 per hour expenses such as office overheads, continuing professional development, registration, insurance and professional supervision). Removal of the two tiers and adoption of a rebate that better reflects an appropriate remuneration for services would encourage more psychologists to bulk bill or reduce the gap fees charged – an issue of critical importance considering the disruption chronic mental health can cause to employment and economic activities.

Further to the discrepancies in client service posed by the two tier model, is the different categories for therapy under the Better Access program: Focused Psychological Strategies (which covers what non-clinical psychologists can use with their clients, and Psychological Therapy Services (clinical psychologists only).

Focused Psychological Strategies dictates a restrictive set of psychological techniques akin to restricting the practice of a mechanic to changing brake pads only. All psychologists are educated and trained in the main therapeutic approaches of psychology and psychotherapy. However, many of us have completed further non-university based study in areas such as Acceptance and Commitment Therapy, Schema Therapy, Trauma-Focused Therapies, Narrative Therapy, Dialectical Behavior Therapy etc. Psychologists who have completed further training in these areas and feel competent in their delivery, should be able to use the evidence-based approach that is most suited to the client, however Medicare requirements have effectively restricted two thirds of the psychologists working in private practice from being able to offer their clients what is professionally considered effective, and in some cases best practice or gold standard treatment, for their presenting concerns.

Public and Community Mental Health Services

Better Access is touted as the solution to mild to moderate mental health concerns, however there is a heavy burden placed upon the Medicare system to provide service to severe to extremely-severe mental health presentations where the public health system cannot accommodate patients for a number of reasons.

A case study is most helpful to illustrate the shortfalls experienced by consumers and mental health practitioners alike on a daily basis in both urban and regional areas of Australia.

Client A is a 23-year-old woman referred by her GP to a psychologist under the (then) ATAPS (Access to Allied Psychological Services) initiative. She is employed, in financial hardship and experiencing symptoms of depression that cause disruption to her employment activities (absences from work). Under ATAPS she uses 12 sessions with a psychologist and is identified as having Borderline Personality Disorder and Post Traumatic Stress Disorder. She is no longer eligible for ATAPS, having used her session allowance for the year, and (at the time) was not allowed to transition to Medicare service delivery. Her symptoms have continued to fluctuate during her treatment as she is not responding well to medication, but for financial reasons cannot afford to see a psychiatrist privately. She has been referred to the public mental health system for psychiatric review on several occasions, and presented to the emergency department for suicidality and self harm on another occasion, however the intake team at the hospital's mental health unit say she is not eligible for service (her symptoms are "not severe enough") and refer her back into her GP and private psychologist's care each time.

It is mid-year and Client A is no longer eligible for ATAPS or Medicare for the remainder of the year and cannot afford private fees so a referral to Headspace is made. They advise that because of her age (Client A has since turned 24) she would only get a few months of help from them and they would prefer not to accept the referral, as this "bouncing" in and out of services could be therapeutically contraindicative. Client C agrees to a plan to see her GP weekly for support until the New Year when she will be eligible for further assistance under Medicare.

In the new calendar year, Client A's GP refers her once again to the private psychologist (whom she trusts and has good rapport with) through a PHN initiative. Once again, she uses her 12 funded sessions, however this year the Department of Health decide that service delivery under PHN funding and Medicare is now allowable within the same calendar year, and Client A transitions to Medicare sessions after her PHN funding is exhausted. At this time she is experiencing unrelated health complaints that are exacerbating her experiences of anxiety and she becomes suicidal again. She is again referred to the public mental health system and presents to their emergency department with self-harm and other injuries related to suicidality on several occasions. She is again refused case management and informed her GP and private psychologist are adequate supports.

Client A exhausts her Medicare rebatable sessions shortly after and is once again referred to public mental health as she continues to experience suicidality and self-harm. She is accepted for a Dialectic Behaviour Therapy programme and told there is a six-month waiting list before she can commence. Client A once again agrees to meet with her GP weekly for reviews and monitoring in the absence of other supports. Client A also borrows money from family to pay for private health insurance and a private psychiatrist. She waits the mandatory 3 month waiting period imposed by her health insurer and is immediately hospitalised by her private psychiatrist for Electro-Convulsive Therapy. She remains an inpatient for nearly 8 weeks.

The above case study is a real example of a client considered to have severe to extremely severe presentation and represents the struggle consumers experience every day to access publicly funded mental health services. In this instance the client eventually gave up, after more than 2 years of trying, to pursue treatment in the private industry. By this stage her mental health had deteriorated to the point of needing invasive and risky treatment (ECT) to address. She was fortunate enough to have family who helped her manage the cost of private health insurance – this is assuredly not the case for the majority of clients experiencing disruptive mental health symptoms.

Whilst not familiar with the inner protocols adopted by the public health system, and therefore not in a position to recommend specific change, from this experience I would propose a major review of how funding is allocated and utilised within the public health system for delivery of inpatient and outpatient case management services, including psychiatry, psychological intervention, outreach, social work and group therapy programmes. I would also suggest that collaboration with private industry and better awareness by both sides of the challenges and limitations of the other may provide more informed choices around service delivery models to reduce the risk of clients, like Client A, falling through the cracks.

Conclusion

I propose the following in relation to the abovementioned concerns:

- I propose that mental health care funding made available to clients to access the private sector (i.e. Medicare) look to increase both the number of sessions available per year (to better meet what is recognised as best practice or gold standard for treatment) and the rebate available to provide the public with better access to mental health treatments that are timely and effective – thereby reducing the risk of chronic, repeat presentation for services (and costs associated with the disruption to economic activities caused by mental health concerns).
- I propose review to the standards imposed by Medicare for the delivery of group therapy services with a view to reducing economic risk to clients and providers alike, and increasing accessibility.
- I propose removing the two-tier rebate system in favour of equality and a single Medicare rebate for psychological services.

- I propose that FPS be removed altogether as a category for psychological service under Medicare, and all psychologists are able to deliver evidence-based Psychological Therapy Services without restriction.
- I propose that public health funding and service delivery for mental health services be reviewed and consultation with the private sector be undertaken to identify service deficits and provide a consistent framework for assessment, eligibility and client inclusion for all public and community mental health services, nationally.

Yours sincerely,

Emma-Kate Muir