GERALDINE LUM M.PSYCH.(CLIN)
CONSULTANT PSYCHOLOGIST

A Psychological Health Service
Specialising in Grief, Anxiety Disorders & Depression

PROVIDER NO. 2588591 B
A.B.N. 50 323 144 781

Senate Community Affairs Reference Committee
Community.affairs.sen@aph.gov.au

CC: Minister for Mental Health
ministerbutler@health.gov.au

18 July 2011

Dear members of the Senate Community Affairs Reference Committee,

Re: Terms of Reference of the Senate Community Affairs Reference Committee inquiry into Commonwealth Funding and Administration of Mental Health Services

I am concerned about the proposed changes to the Better Access to Mental Health Care Programs as set out in the terms of reference to the Senate Community Affairs Reference Committee. I wish to address three points under the terms of reference. They are the quantity of sessions allocated to consumers of Better Access to Mental Health Care Programs, the two-tiered scheduled fee Medicare plan for psychologists and the impact of online services for people with a mental illness, with particular regard to those living in rural and remote locations and other hard to reach groups.

b-iv). The quantity of sessions allocated to consumers of Better Access to Mental Health Care Programs.

Prior to the introduction of Better Access to Mental Health Care Programs in November 2006, patients with complex mental health problems and/or co-morbid presentations, were seen by psychiatrists, community mental health workers and/or General Practitioners (GPs). Since November 2006 these patients now have the opportunity to consult with private practicing psychologists, in particular, clinical psychologists who are highly trained at treating patients with these conditions.

If there is a reduction in the number of psychology sessions, as has been proposed, the people most affected by the reduction of these sessions are those with complex mental health problems and/or co-morbid presentations (predominantly substance abuse and mental health disorders). These patients will not do well with early cessation of treatment. At the end of 10 psychology sessions there is every reason to expect these patients will return to their GPs again and again because of insufficient treatment of care. In many clinical trials of Cognitive Behaviour Therapy the number of sessions provided for effective treatment is 12 and that

does not include assessment of the client, maintenance of improvements or review of progress. With the changes proposed psychologists are expected to assess, treat and review all within 10 sessions.

Many may argue if a patient still requires psychological treatment after 10 sessions, Community Mental Health or the Drug and Alcohol Service are the next best point of referral. The wait lists for these services are long and there is no certainty these patients will be seen by a clinical psychologist in the system. At triage they may be allocated to a mental health nurse, social worker, psychologist or counsellor. Having worked in both Community Mental Health and the Alcohol and Drug Service, I can confidently say that the single most influential factor that governs the allocation of patients is not the appropriateness of the skills base of the clinician but the size of the caseload a clinician is managing.

When Better Access to Mental Health Care Programs came into force in November 2006, the one outstanding comment made again and again by GPs was the ease with which they could shift their complex mental health patients to psychologists who could provide more effective treatments. If psychology sessions are reduced to a maximum of 10, GPs will once again find themselves babysitting these patients. In addition to this, their available time to provide primary health care to other patients in the community will be further limited as a consequence. There is no certainty that there will be any savings for Medicare either. It is likely that the opposite is true as the costs for carrying untreated mentally ill patients in the community will be borne by GPs. Where GPs fail to provide primary care to members of the community, hospitals become the next point of contact for the sick. Expect more patients in Departments of Emergency Medicine (DEM) for conditions that GPs can treat but can't because they are otherwise occupied. Similarly, expect a rise in the number of complex mental health patients presenting in DEM because these patients can't receive appropriate treatment either. For these reasons, do not expect to see either economic savings or improved health outcomes from the proposed changes.

i). The two-tiered scheduled fee Medicare plan for psychologists.

The plan to remove the two tiered Medicare system of remuneration for psychology is of great concern for the profession of psychology. It poses a serious threat to the profession because it both deskills the profession and removes the financial incentive to undertake training in clinical psychology. Undergraduate psychology training of four years plus two years of supervised professional practice is not the same type of training as postgraduate training in clinical psychology. It produces a different type of psychologist. A four plus two (four years undergraduate training plus two years of supervised professional practice) can only be as good as their individual supervision and experience permits because there is no standardised training for them, no standardised exposure to clinical conditions, no measurement of their performance or skill level. For example, they can be supervised by a single supervisor for two years in relationship counselling, an area that does not attract a Medicare rebate. From this they can gain their ticket to practice psychology under the Medicare system and work with patients with complex mental health disorders. This does not occur in post-graduate training in clinical psychology where minimum standards have to be achieved by the training course (APAC accredited courses) and the students (minimum of an Honours level of undergraduate training, two years of clinical course work, four different clinical placements amounting to 250 hours each, a research thesis and two further years of supervised clinical practice).

Embarking on post-graduate training in clinical psychology takes years. In most cases more than the stipulated years as very few complete within the minimum years specified. Many taking more than two years to complete a Masters program, more than three years for a professional doctorate and more than four years for a clinical PhD. If the remuneration is to be the same for those with undergraduate degrees plus two years of supervision (generally

undertaken whilst salaried at their supervised workplace), how many psychology students will choose to give up years of their life and income to undertake post-graduate training in psychology when within two years of completing undergraduate psychology they can be certain of earning a Medicare rebate for their clients? If the two tiered system is removed expect to see a reduction in the number of enrolments in the Schools of Psychology across Australia and over time expect to lose the skill set that clinical psychologists currently have because there won't be the generations studying clinical psychology to teach the next generations to come. What will be the impact of this on the clients who need that skill set and the profession of clinical psychology? Whilst other countries like the United Kingdom and United States of America require Doctoral degrees in Psychology to practice, Australia will be in the unique position of requiring only a four year degree plus two years of supervised work experience to practice psychology.

As a general psychologist, a four plus two, who has spent the past eight years studying for a Masters in Clinical Psychology whilst working full time, I am well aware of the sacrifices I have had to make to achieve my qualifications. I am also well aware of the impact my studies have had on my practice. The psychology I practice today is not the same as that which I did eight years ago as my studies have directed my practice to a different place. As one who has been a general psychologist in private practice for the past 10 years I feel qualified to say that the skill set of a clinical psychologist is different to that of a general psychologist. The introduction of a single rebate for both clinical and general psychology not merely fails to recognise the difference in skills but more dangerously, it will over time eliminate that very skill set the community needs.

h). The impact of online services for people with a mental illness, with particular regard to those living in rural and remote locations and other hard to reach groups.

For those living in rural and remote areas of Australia, on line delivery of mental health services is vital, particularly if it is through a medium such as Skype as it permits visual contact between the clinician and the client. Presently, there are many who are not able to access mental health care from psychologists because there are none in their region. With the introduction of better technology through the national broadband network, the delivery of psychological therapy via Skype becomes feasible. It provides access to psychological help where none has existed before, and exploration of this medium to deliver psychological services is to be commended.

Yours sincerely,

Geraldine Lum
Psychologist MAPS