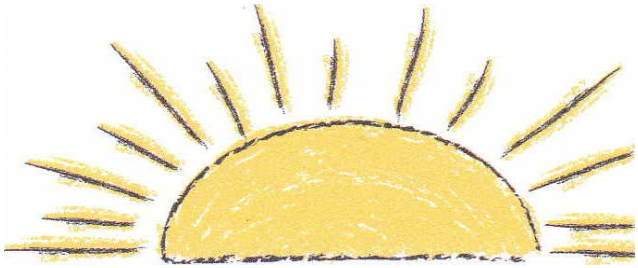

New Day Psychological Services Pty Ltd

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

RE: Submission to the Senate Select Committee Inquiry for Commonwealth Funding and Administration of Mental Health Services

Contact: Dr Denise Robertson, Director
info@newdaypsychology.com.au

26th July 2011

New Day Psychological Services Pty Ltd.,
8/135 Ferny Way,
FERNY HILLS QLD 4055

Phone: 07 3351 2222
Fax: 07 3351 1222

Introduction and Background

Thank you for the opportunity to make a submission to the Senate Standing Committee Inquiry on Commonwealth funding and Administration of Mental Health. I am a Clinical Psychologist who established New Day Psychological Services in 2008.

With the introduction of the Medicare funded Better Access initiative I was able to pull together my training and experience as a clinical psychologist with my background and knowledge of mental health policy to begin to deliver *AFFORDABLE AND HIGH QUALITY PSYCHOLOGICAL SERVICES DIRECTLY TO WHERE PEOPLE LIVE*. I have modelled my practice on the priorities and spirit of the NATIONAL MENTAL HEALTH PLAN and the Better Access initiative.

We are a stand alone group psychology practice but have very close relationships to our local community. Our referrals overwhelming come from five local GP clinics within walking distance to our practice. We have established working relationships and lines of communication with the over 100 GP's who refer to us regularly. Some brief statistics which may help understand our capacity and work are: -

- We are a fully functioning clinic with an office manager and full administration support. Our psychologists are employed to deliver psychological services only and community liaison as required.

- We are open six days a week including two evenings and Saturdays. Our five psychologists are consistently booked. Between us we see approximately 10-15 clients per day.

- Our five psychologists have a wide variety of experiences and backgrounds. We have a team approach (varied skill mix) so we can cater to wide variety of presentations from the general public. As a clinical psychologist and with my background I have experience in seeing people with severe mental illnesses including psychosis, and eating disorders. I have attracted two psychologists with postgraduate training in clinical psychology. However, we have also employed general psychologists who are

very experienced and developed special interests in aging and workplace issues, child and family therapies. We see all ages including children and at risk young people regularly. We have a family friendly ethos and with our model can work with couples and whole families appropriately and ethically.

- Since we opened our doors (two rooms in a central shopping hub) in Suburban Ferny Hills we have seen almost 800 individual clients.

- We receive approximately over 20 *new* referrals a month.

- We aim to provide affordable access with bulkbilling available to pensioners and reduced fees for hardship. *Maximum* out of pocket expenses for full fees are $50 for Medicare referred clients.

- We are able to achieve this with a cost recovery model effectively breaking even with our operating daily costs equating to $500 per day plus wages.

- As an employer of psychologists we operate under industry based and training standards established for psychologists. Including competitive pay rates, and working conditions.

- We have high quality assurance standards. We collect evaluation data above what is required by Medicare and conduct audits.

Proposed Changes to Better Access and Service

The Mental Health of Australians has been a long neglected priority until the Better Access Scheme was introduced in 2006. The prevalence and burden of mental health disorders including high prevalence disorders such as anxiety and depressive disorders, and substance misuse, as well as the low prevalence disorders (psychotic disorders and eating disorders) are well documented. We would argue, as others have argued over decades, that the public health system has traditionally excluded the vast majority of people struggling with their mental health (anxiety, depressive disorders, and substance misuse). To gain access to the public

mental health system people have to be in immediate crisis either psychotically unwell, suicidal or an immediate risk to others. We would argue that even with this small but vulnerable group of Australians that the public system is failing with its focus on crisis intervention and minimal follow-up and access to evidence based psychological therapies.

Our concern regarding any changes to the Better Access initiative is based not only on our experience with our practice but with the overwhelming national success of the utilization of the Better Access Scheme by the people it was designed to help, ordinary everyday people struggling with their mental health. We question the wisdom and effectiveness of "cutting costs", if the end result is that in real terms the people who we see day in and day out will be left without adequate mental health care. We know from others and our personal experiences that what we do makes a difference. We help people to stay alive, to develop healthy habits and lifestyles, we help families to stay together, we help people to keep their jobs, we help parents to parent better and raise healthier and happier children. We do prevention in the very real sense. We aim to not only deal with the crisis which people typically present to us in, but to help them and their families to learn the skills to be as healthy as they can be into the future.

All of these very real outcomes make good fiscal policy and sense. By putting mental health money into primary care, money is saved in the longer term by keeping people out of hospital, keeping people in their jobs and off unemployment or getting back to work quicker etc. The savings in terms of reduction in suffering is harder to measure. We submit feedback given by our clients on the impacts of the proposed changes to their ability to access us in real terms (Appendix 1).

As above we are concerned with any changes to the Better Access Initiative regarding the impact it has on everyday Australians mental health and our clinics ability to service our local community. However, there are two terms of reference which concern us the most. We will now speak to these:-

Term of reference (b) Changes to the Better Access Initiative (ii) (iv) (c)

(b) Our major concern is the proposed REDUCTION in services from up to a maximum of 18 down to maximum of 10 sessions per year. We would argue strongly that this reduction would harm some of the most vulnerable people in terms of mental health need and leave them with their only access to an overly taxed public mental health system. My concern is that this is based on an erroneous assumption that people with severe and complex presentations are not accessing psychologists under the Better Access Scheme. In our clinic the majority of clients are presenting with high prevalence disorders (Anxiety and Depression) but generally they are in the moderate to severe range (DASS: Depression and Anxiety Scale). The considerable number of clients who we see who access our clinic for 12 to 18 sessions are those who are more complex and needing those extra services. In mental health co morbidity is the rule rather than the exemption. Examples of complex presentations we see frequently are people presenting with chronic mental health and health conditions (long term UNTREATED ANXIETY AND DEPRESSIVE DISORDERS), People with SIGNIFICANT COMORBIDITIES SUCH AS UNTREATED TRAUMA AND ADDICTION DISORDERS. The problem for this overrepresented group is that the public sector traditionally does not cater for them. They may be come into contact with public mental health services in crisis but find it difficult to access ongoing psychological interventions. Access to psychiatrists is expensive and difficult in the private sector. The same argument applies to the low prevalence disorders that we see in our clinic, specifically first presentation psychoses and eating disorders. Access to the public system for these very vulnerable groups and adequate intervention is very poor. We cater for these groups in our clinic, but they need typically intensive intervention and follow-up.

(c). The impact and adequacy of ATAPS, Our major concern is based on our experience with the capacity of ATAPS to service the group we have already highlighted, people with high prevalence mental health disorders. We would argue that any yet to be formulated program via ATAPS would add another level of bureaucracy.

We would argue that on our past experience the coordination and administration of ATAPS has been poor due to limited staff and funding. In our local GP division there was only one

employed (dedicated but overworked) psychologist/coordinator. The paperwork required as a psychologist to apply as a provider then comply with ATAPS work was also extreme and off-putting. I would frequently have clients presenting to me via the GP (mind scheme) who had not completed all the "required" paperwork correctly and I would have to chase the poor coordinator to find out whether I would be out of pocket if I saw my client or not.

(e) Mental Health workforce issues

(i) The two-tiered Medicare rebate system for psychologists.

I find it personally insulting to have to defend my right and other APS clinical college members right to an extra rebate because of our specialist title. I do not begrudge other specialists in the APS or any psychologist their specialist titles and entry into their specialist colleges based on their extra training and experience. However, clinical psychologists *have* extra training in the *speciality* of mental health. Unlike the other nine APS specialities we have extra training at a postgraduate level in the aetiology, diagnosis, and evidence based treatment of mental health issues. We have the equivalent of a Masters and/or Doctorate in Clinical Psychology. Entry into Master's and Doctoral programs in clinical psychology are very competitive and expensive. Any graduate will attest to the demands of training in terms of the quality and the costs. I engaged in this extra training because I wanted to be a better smarter *specialist* clinical psychologist not to earn extra money. The difference in rebate compared to what I have put in is not worth it. I was a clinical psychologist like many in the clinical college before the introduction of Medicare rebates.

I dispute and would demand evidence that a four year trained generalist psychologist or any other allied health professional or other APS non clinical college member has the equivalency in terms of competency in the aetiology, diagnosis and psychological treatment of mental health disorders as a graduate of a Masters or Doctoral Program in clinical psychology. These programs have very high standards with the associated stringent requirements of supervised practice and formal assessment of knowledge and skills. In defence of the APS Clinical College it has always had a clause whereby psychologists without this graduate training can apply based on *evidence* of competency.

The difference in the work value of clinical psychologists versus general psychologists has been accepted in some industrial settings and we would submit the arguments outlined in the Work Value Document prepared by the HSOA Clinical Psychology negotiating Committee to the Royal Perth Hospital, WA (Appendix 2).

Presently in my clinic I am effectively paid the same as my generalist colleagues! On a local level if my clinical psychology rebate were cut to the generalist level then that would seriously undermine the financial viability of our clinic. At present my higher rebate offsets the loss of bulk billing at the general rate (I have to charge $110 per hour to break even). The result for us if we lost the clinical college rebate is we would have to increase our fees or stop bulk billing. At present we bulk bill vulnerable groups (people on centrelink benefits) who are usually people with the most serious and complex mental health problems not able or wanting to access the public sector. For our clinic the proposed change will disadvantage the most vulnerable groups in our community. *Hardly Better Access.*