Commonwealth Funding and Administration of Mental Health Services

Information about the Inquiry

Please accept this submission to the Senate Community Affairs Committees for inquiry and report.

The Government's funding and administration of mental health services in Australia, with particular reference to:

(a) the Government's 2011-12 Budget changes relating to mental health;

The government was not exactly truthful in the budget changes to metal health It was largely a redistribution of funds and creative accounting on their part rather than offering this country the high quality mental health facilities and treatment options that the people need and deserve. The funds are spread over a long period yet again delaying much needed funds into this failing sector.

All in all it will mean less clinicians for more clients. Long delays in the system for those who are most vulnerable. This has to be addressed. The changes to the medicare system for GP's and allied health professionals are a prime example of this. Reducing a patients access to treatment helps nobody. It just increases the mental health issue for those who need the help the most. This is especially the case for those in rural and remote areas of Australia where health services are already hugely inadequate.

(b) changes to the Better Access Initiative, including:

(ii) the rationalisation of allied health treatment sessions,

This was not as much of a rationalisation of allied health treatment sessions as a destructive cost cutting measure designed to fund the political promises made by a government in order to mislead the public into believing they were getting a better mental health service and system country wide. In fact it has meant that many people who need more sessions in order to be discharged being well, are deprived of these and more likely than not will relapse. The system cannot rely on medication alone as this does nothing for the longer term management of mental health patients. We need a robust system where gp's, clients and clinicians work closely to ensure the best outcomes for our patients

(iv) the impact of changes to the number of allied mental health treatment services for patients with mild or moderate mental illness under the Medicare Benefits Schedule;

There are a number of issues here:

As a Psychologist, we often get a referral from a GP stating that a client has depression and or anxiety. Much of the time there additional issues such as drug and alcohol issues, suicidal ideation, some have autism others eating disorders some are paranoid others have psychosis many have grief and or trauma some have been the victims of long term domestic violence which together mean longer term interventions. The mental health teams are becoming more restrictive in who they are seeing which means that more complex , severe and longer term cases are being seen by private psychologists. The fact of the matter is we are getting more cases through medicare because the mental health teams cannot handle the volume. As such, this has to be taken into consideration with the medicare funding.

For those patients that require less session they get less sessions. There is no point in giving a client any more sessions than they need. The extent of the issue is so great across the country but especially in rural and remote areas that there are not enough clinicians to meet the needs of mental health patients.

There are several important parts to treatment the first of which is assessment. This takes time and can require two sessions in many complex cases. Trust and rapport has to be made in order for some patients to fully disclose their issues. Again this takes time and the clinician works hard to ensure that this happens as soon as possible. Treatment requires many things but much of the time it require effective intervention strategies and time for those strategies to be worked through. The new system does not allow for this. Nor does it allow for adequate relapse prevention work to be done with the client to ensure as much as possible that the client does not return to a poor state of mental health. If they do they are better equipped to manage their episode which often means a better outcome.

Personally I would like to see telephone and internet sessions included under medicare. I feel that this would ensure a wider coverage of service for our rural and remote clients. This group has limited public transport options and many have no transport at all. This places them at a distinct disadvantage to receive the appropriate interventions they require. I already do this under other schemes and it works well. In some areas there are high numbers of last minute cancellations and no shows for sessions. This would be greatly reduced if medicare allowed for telephone and internet sessions.

(c) the impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program;

As the recent medicare review showed, The level of services offered by Psychologists is good and there are definite and measurable benefits to clients. This is regardless of whether you are an endorsed or generalist Psychologist. The fact that GP's now refer to Clinical Psychologists means, in my opinion, that clients are disadvantaged and cannot afford the gap. They also do not have access to excellent clinicians who have been working in the area for many years. In order to have a fair and equitable service for all the two tier structure must go and a level playing field be used to the full benefit of our patients.

(d) services available for people with severe mental illness and the coordination of those services;

There are not enough services available for people with severe mental illness issues and the coordination of those service is lacking. Recruitment and retention of staff is a huge problem which severely impacts on the patient. Private clinicians do work with this group on a regular basis but are not covered appropriately under medicare. One possible answer is to have a greater monetary amount paid to external private clinicians who work with clients from this classification and these would be decided by either a GP or Psychiatrist in their referral.

There are not sufficient Psychiatric services in this country which is made much worse in rural and remote areas. These services must tap more closely into systems which include Private Psychologists and other clinicians. By doing this there is greater value for money from the government but a much better patient outcome. Which we are all working towards.

(e) mental health workforce issues, including:
(i) the two-tiered Medicare rebate system for psychologists,

This is a fundamentally flawed system and most discriminatory. I felt that when this came in it must be illegal to discriminate a profession based on whether they chose to a member of a society and a particular college within that society. I have no issue with clinical psychology or clinical psychologists. But I belief that I provide the same level of clinical services to my clients as a clinical psychologist does. I attend as much if not much more on going professional development than most if not all clinical psychologists and yet I am punished for not being in a particular small group of professionals at the time of the transition.
Personally I do not believe in charging a gap but I must under the current arrangements. I would love to be in the position of having the clinical rate and not charging my clients who the vast majority of whom cannot afford the gap and as a result do not complete their sessions. This often leads to a relapse in their condition.

The system was not fair in its creation especially for rural Psychologists. I moved state so that I could have a clinical supervisor under the old system so that I could get membership and endorsement but the government moved forward the dates by around six months which meant that I was effectively locked out of the system. I had no clinical Psychologist in my previous region so this was not an option for me. When I contacted the APS for assistance here I was informed that my society were not allowed to help me.

There should have been a grandfather clause as has been the case in the past to give those with experience the right to have that endorsement or a more preferred option from my point of view that we are all paid the same and if you want to specialise then you charge your client the extra and leave it up to them to make that choice.

Personally, I have been attending clinical professional development long before these changes came into being. I provide a clinical service to clinical clients but I am not allowed to call myself a clinical Psychologist. I also am Forensically trained to a post graduate level. I have been writing reports for the court for years and have been used by police services and corrective services for assessments and pre sentence reports. Yet now because I am not a college member I am locked out through no fault of my own. This is a disgrace.

I pride myself in providing a high quality professional service to my clients and agencies alike. I would like for there to be a cessation of the current system and reverting back to where it was. A single medicare tear should be in effect of around the $100 per session where the 12 plus 6 sessions should be reinstated. I believe that if you do not charge a gap then you receive the $100 if you do charge a gap then you receive $20 less from medicare. This in itself would help keep a lid on costs. I am happy with college membership but we all have to be able to have access to this if we wish. I don't mind jumping through hoops to get there but there has to be hoops in place to enable you to jump through them.

The historical grandfather rule should be restored and sufficient time should be given to clinicians to make the appropriate arrangements for college membership. I have no problem with the idea of specialist positions. But extra focussed training in discipline areas should provide that not college membership. For example, Attending advanced regular training in Post Natal Depression, Courses on Psychopharmacology, presenting papers in the area and working for sufficient periods with the client group could all be measures of obtaining speciality in that area.

(ii) workforce qualifications and training of psychologists,

I have a Bachelor of social science degree majoring in Psychology and Criminology. I also have a Post graduate diploma in forensic psychology as well as a post graduate certificate in Psychology in legal and penal contexts from a Scottish university which was half the UK masters in forensic psychology degree. I have started a PhD in psychology which was cut short due to funding cuts at the university level and I am about to restart this at another university. I participate in many professional development training initiatives throughout Australia on a very regular basis as well as making use of the electronic media in delivery of courses especially since I have been in a rural and remote practice (as a counsellor and Psychologist) for over a decade. Most of my training outside University is clinical in nature as most of my clients require clinical intervention. Yet I am not a full clinical college member nor am I endorsed as a clinical Psychologist.
and

(iii) workforce shortages;

The advent of Medicare was fantastic for so many reasons. It enabled clients to have much better access to clinical help in a more affordable way. However by the creation of a two tiered system in Psychology, it has driven a wedge in the profession and reduced many university cources to nothing. Most clinicians are scrambling for the few clinical places available. Which means interest in the other discipline areas are drastically reduced. To the degree where universities have been closing whole departments and laying off staff and academics.

In effect this will mean fewer well qualified clinicians across the board but real shortages in many areas such as educational, organisational, health and forensic Psychology to name a few.

It is historically difficult to recruit and retain staff in rural areas and this will just make this task more difficult. It will mean that when young people move to the cities to get educated, fewer will return to their regions after they qualify. The cost of living in these areas is already high and public transport practically non existent in many areas. Staff across the board need incentives and access to professional development and quality training in order to stay in these areas. This especially true with the new requirements for PD in Registration and medicare requirements. Supervision is difficult to get in rural areas where there is only one Psychologist in hundreds of kilometres. This has to be addressed for the longer term sustainability of clinical service in rural and remote areas to continue.

(f) the adequacy of mental health funding and services for disadvantaged groups, including:

(i) culturally and linguistically diverse communities,

Training must be made available to clinicians in this area. There is a real need in rural areas where there are large numbers of people who come from many countries through out the world who have special needs such as religious and language requirements.

Better access to translator services are needed and with a flexible delivery system. These have to be cost effective and be able to use technology other than the telephone to deliver services.

Video conferencing and skype are two which need to be considered as well as the availability of these services to rural and remote communities around the clock.

(ii) Indigenous communities

There are few services for this group who are disproportionately represented within mental health as well as drug and alcohol.

Again access to services in rural areas is an issue as are language barriers in some areas. There are some issues about delivering services to remote communities given distance issues as well as increased costs for clinicians and service providers alike. Here is another example where the use of technology across the board would help. By allowing clinicians to conduct sessions electronically and paid for by medicare, it would have the potential to greatly improve the quality of health and life of our aboriginal communities.

(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;

In my view Medicare should cover sessions with clients who are seen on the internet, by skype or on the telephone. There has been significant movement in this area and the government should be commended for the support in this area to several initiatives including anxiety online. However, there is a real need to expand this to medicare for clinicians in a designated rural and remote region. This would greatly enhance clinical outcomes and improve access to these services for all in a rural and remote region. We have the technology and there are clinicians including myself who use these mediums to great effect already. However the cost are prohibitive to clients who cannot have a medicare rebate for this form of service delivered by private clinicians.

The Committee is seeking written submissions from interested individuals and organisations **preferably in electronic form submitted online** or sent by email to

community.affairs.sen@aph.gov.au as an attached Adobe PDF or MS Word format document. The email must include full postal address and contact details.

Alternatively, written submissions may be sent to:

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

Notes to help you prepare your submission are available from the website at http://www.aph.gov.au/senate/committee/wit_sub/index.htm. Alternatively, the Committee Secretariat will be able to help you with your inquiries and can be contacted on telephone +61 2 6277 3515 or facsimile +61 2 6277 5829 or by email to community.affairs.sen@aph.gov.au.

Inquiries from hearing and speech impaired people should be directed to Parliament House TTY number 02 6277 7799. Adobe also provides tools at http://access.adobe.com/ for the blind and visually impaired to access PDF documents. If you require any special arrangements to enable you to participate in the Committee's inquiry, please contact the Committee Secretariat.

Once the Committee accepts your submission, it becomes a confidential Committee document and is protected by Parliamentary Privilege. You must **not** release your submission without the Committee's permission. If you do, it will not be protected by Parliamentary Privilege. At some stage during the inquiry, the Committee normally makes submissions public and places them on its website. **Please indicate if you want your submission to be kept confidential.**