

**Mandy Juniper
Clinical Psychologist**

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Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
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Introduction I write regarding the successful programme to provide primary mental health services to the general population through Medicare funding to private practitioners using a two tiered system. It is interesting and disappointing that the outcome evidence of the success of the programme (take-up rate) is now being used to contemplate cuts to the service, as the original format of the programme showed an exemplary clarity of thought in terms of meeting the needs of the general population and health service providers.

My qualifications I am a Clinical Psychologist in part-time private practice, working in a regional centre. I have worked since 1986 as a specialist in Perth, starting in a Teaching Hospital providing children's health services through the Department of Psychiatry, and then in a Community Health Centre and also a Tertiary Outpatient Psychiatric Service (two part-time jobs). I then relocated to Broome West Australia where I worked for 9 years for the Department for Community Protection, where I was exposed to the issues relating to Aboriginal health. Then I took up private practice. Thus I feel qualified to make comment from a wide base of experience.

My referral base The Better Access Initiative has resulted in a wide range of patients being able to take control of their lives without becoming dependent on centralized services with extensive waiting lists. As a Clinical Psychologist I see a range of patients, some who have mild mental health problems, but others with entrenched behavioural and emotional dysfunction. These are referred to me by Hospitals in Perth (Princess Margaret Hospital for children) by General Practitioners and through self-referral. In the latter

case it is helpful to encourage attendance at a General Practice in order to get the accompanying medical and financial support for the more seriously dysfunctional people.

Terms of Reference : b Better Access Initiative iv) Number of sessions

I work in the country, where I believe there is less dependence on specialists. Yet I have seen people who have needed more than the usual 12 specialist sessions. Yes, more of my patients only need up to about 6 sessions till they feel they can manage (we could call them the mildly affected), a significant proportion need between 6 and 12 (the moderately affected), and only a few need access to the 18, thus in my terms being more seriously affected. Just because the proportions vary surely does not mean that the service is not needed. Reducing the ceiling to me means enforced premature conclusion of intervention in more seriously affected cases, which is known to result in relapse, and longer term problems.

Terms of Reference : e Mental Health Workforce Issues: (i) Two tiered

system for psychologists I am particularly concerned that the two tiered system could be dispensed with. I spent two years in intense academic study in a Master's Programme at an approved University in an approved course, resulting in academic recognition of my efforts, and provisional registration with Psychologists' Board of WA. Then followed work under supervision for two years before I was able to be fully Registered as a Clinical Psychologist, in, interestingly, the only State that had legal recognition of the import of such a career path, and one in line with international standards of health care delivery, but out of step with most of Australia. I still felt inadequate when starting out, yet it is being suggested that people with much less training and supervision could do the same work as competently.

I find it interesting that there is no confusion about the value of the specialist medical workers – one first goes to the general practitioner and for the complex cases there are a range of specialists, whose expertise is recognized as essential in the health industry. I don't understand why this cannot be recognized in the psychology profession. Why should my efforts at acquiring knowledge and skills at an advanced level be dismissed as similar to those who have spent less time at the profession in close study of the factors associated with serious mental health dysfunction.

There are longer term implications to the community also, if one were to devalue the work of the Clinical Psychologist by paying them the same rates as the four year trained people. There would be less incentive to further study in the specialist area of mental health dysfunction, thus eventually resulting in a less efficient, effective service to the community. This

obviously also has relevance to items (ii) and (iii) in the Terms of Reference point e, Mental Health Workforce issues.

I have heard that there is a suggestion that a better use of the funding would be to provide staffed services for the more seriously disturbed, assuming that the more seriously disturbed are not already receiving services, and they could be better served with an alternative tertiary service to what is available.

The provision of the primary health intervention of Better Access was inspired in that it recognized that the community is more interested in self-care than dependence. Waiting for the services of the agencies usually means long waiting times and consequent disillusionment with the bureaucracy and deterioration of quality of living for the afflicted.

And the beauty of this current system is that it relies on the providers to provide the accommodation for health services, rather than a centralized service of employed staff who would need buildings to be provided as part of the service costs. Spending a large portion of a budget on buildings when the service is already available in the community does not seem to me to be a wise use of funding.

Conclusion An additional comment I have which may have bearing on budget outcome relates to the exchange of information between Psychologist and General Practitioner. The notion of reports being sent by the psychologist to the GP is good, yet it seems to me that the psychologist is required to put in the time into writing the report with no extra payment for such work, while the GP gets paid a handsome sum in order to read such a report. In terms of adequate recognition for equivalent work, this seems to be contrary to common practice. I would hope the Committee in its wisdom could alter this imbalance.

Final Recommendation from a Clinical Psychologist's view

- The two tiered system of payment should continue, thereby providing those workers with more training and experience some recompense for their extra expertise and skills, and recognizing that the public does benefit from contact with them.
- The ceiling to the number of sessions be reduced to 10 generally, with an extra 6 being accessible under the same conditions currently operating for those exceptional cases.
- Psychologists be paid for the writing of the reports to GP. This could be funded by paying the psychologist half the fee currently given to the GP reading the report.

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Appendix 1: Terms of Reference.

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Terms of Reference

Senator Fierravanti-Wells, also on behalf of Senator Siewert, amended business of the Senate notice of motion no. 1 by leave and, pursuant to notice of motion not objected to as a formal motion, moved-That the following matter be referred to the Community Affairs References Committee for inquiry and report by 16 August 2011:
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;
- (b) changes to the Better Access Initiative, including:
 - (i) the rationalisation of general practitioner (GP) mental health services,
 - (ii) the rationalisation of allied health treatment sessions,
 - (iii) the impact of changes to the Medicare rebates and the two-tiered rebate structure for clinical assessment and preparation of a care plan by GPs, and
 - (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;
- (c) the impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program;
- (d) services available for people with severe mental illness and the coordination of those services;
- (e) mental health workforce issues, including:
 - (i) the two-tiered Medicare rebate system for psychologists,
 - (ii) workforce qualifications and training of psychologists, and
 - (iii) workforce shortages;
- (f) the adequacy of mental health funding and services for disadvantaged groups, including:
 - (i) culturally and linguistically diverse communities,
 - (ii) Indigenous communities, and
 - (iii) people with disabilities;
- (g) the delivery of a national mental health commission; and
- (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; and
- (j) any other related matter.