SUBMISSION TO COMMUNITY AFFAIRS COMMITTEE OF THE SENATE

INQUIRY: COMMONWEALTH FUNDING AND ADMINISTRATION OF MENTAL HEALTH SERVICES

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

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INTRODUCTORY COMMENTS

The Terms of Reference of this Inquiry cover a very large number of issues of particular relevance to various groups of stakeholders both professional and community within the mental health sector. Issues of specific relevance to the profession of psychology, to be addressed by the Committee have been the subject of long-standing discussion and debate and are unlikely to be resolved in the time frame of this Senate Inquiry. The broad nature of the Terms of Reference make it difficult to focus on any specific details relating to the provision of funding for a coherent plan for the overall provision of mental health services in Australia.

This submission is based on our understanding of the current needs of health and other community-based service providers such as medical general practitioners, who are the mainstay of mental health care for the community.

We are all Clinical Psychologists based in South Australia. We have an average of about thirty five years experience in mental health including clinical service delivery in a range of health and mental health settings, supervision, lecturing, management, policy development, strategic and service planning.

We are particularly concerned about the impact of limiting the number of sessions available for treatment, delineation of the population for whom subsidised psychological services are available and the training required to provide such services. Our comments therefore focus mainly on these issues which we believe need to be addressed with some urgency.

We therefore present our submission to the Senate Committee for inclusion in the committee's considerations of these matters.

TERMS OF REFERENCE.

(B) CHANGES TO THE BETTER ACCESS INITIATIVE:

(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;

RESPONSE:

The proposal to cut the number of sessions for which clients are eligible from 12 to 6 makes no sense on any grounds other than monetary expediency and concerns about cost blow out. There seems to be no consideration of client mental health outcomes or effective service delivery.

It is our understanding that this decision was based on a research outcome that the median number of sessions was 5 - 6. This suggests that the current proposed cuts have been determined on the basis of outcomes with a population with relatively minor problems.

Patients suffering from long term or chronic conditions for example, schizophrenia, manic depressive psychosis or obsessive compulsive disorders typically require intervention and support over a much longer time, as do survivors of trauma, people who have experienced physical, emotional and sexual abuse either during child hood or as an adult and who present with depression, anxiety and post–traumatic stress disorder.

Some of us have noted that one result of limiting the number of sessions is that some clients will wait until a situation becomes critical to access services in an attempt not to “waste” sessions.

Research has shown that there are a minimum number of sessions required to achieve good outcomes for psychological interventions for specific diagnoses. The number of sessions required by any one person should be determined by the professionals involved according to the complexity and severity of the problem presented. The previous system of extending time when necessary was well received and sensible.

Clinical psychologists have comprised only a minority of the costs of the Better Access initiative. We believe that if the government had stayed with the original proposal to limit referrals to clinically qualified psychologists this matter would not have arisen. It is clear that the costs of services provided by psychologists trained to a lesser level, has been the most significant factor in the escalation of costs so far and the reduced effectiveness of the Better Access initiative in achieving its aims.

TERM OF REFERENCE

Ref (e) MENTAL HEALTH WORKFORCE ISSUES, INCLUDING:

(i) The two-tiered medicare rebate system for psychologists,

Response:

The current two tiered rebate system is a recognition of the difference in levels of training between clinical and other psychologists particularly in the diagnosis, assessment and interventions for mental health particularly for the more severe and complex presentations.

(II) WORKFORCE QUALIFICATIONS AND TRAINING OF PSYCHOLOGISTS,

Response:

Dealing with major mental health and psychiatric problems requires experience and appropriate training.

The role of the Federal Government through the Australian Health Practitioner Registration Agency is to recognise and support a professional standard which will indicate that the Australian Government supports an international standard for Clinical Psychology. It would be a 'courageous' move on part of the Government to provide a third world standard for the treatment of our most disadvantaged. The current dispute cannot be resolved by argument but by ensuring that training is based on the most up to date evidence available, again as is consistent with that of other health professions, including medicine.

The current differentiation between training levels has come about largely because of the intervention of the Australian Psychological Society which represents the professional interests of psychologists. The APS was instrumental in advocating for benefits for as many of its members as possible. Unfortunately the consequences of setting a low training standard which, if adopted by the Committee, would be one of the lowest in the Western world, appear to have been overlooked.

In the U.K for example, Clinical Psychologists undertake a Doctorate in Clinical Psychology (D. Clin. Psych., Clin.Psy.D. or similar), which is a programme with both clinical and research components. This is a three-year full-time salaried program, provided by 30 centres across the UK, sponsored by the National Health Service (NHS). These clinical psychology doctoral degrees are accredited by the British Psychological Society and the Health Professions. These are much the same standards as those adopted by the US and Canada. The New Zealand standard requires a Clinical Master's degree for employment in the government services.

The decision for the Committee is very clear – whether to adopt the lesser standard, not recognised in the majority of other international health jurisdictions, or to endorse a standard that would maintain a workforce of world class training. Our understanding is that the majority of psychological interventions so far funded by the Better Access programme have been by psychologists less qualified to a population that do not represent the most vulnerable and needy. The literature shows that there is an insatiable need for interventions that are brief and supportive for less severe psychological and emotional problems. Such populations are perhaps better served by treatment by other providers who do not depend on public funding. Federal assistance for this population is not a priority and more support should be given to cheaper ways to deal with this population. One such, using the internet is suggested below, under iv h (on line services).

Ref (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;

Response:

As an example of alternative avenues for psychological health, the Committee may be aware of the development of well researched online programmes for various

emotional and psychological problems. As well as intervention for moderate depression (for example BeyondBlue), there are programmes addressing many forms of anxiety and other non-critical conditions. Outcomes so far have been positive and we believe that the provision of information and treatment strategies will greatly help in dealing with these troublesome problems. A greater effort in supporting and advertising these services would help reduce the dependency on professional input.

The current complexities of intervention in mental health are reflected in the fragmentation and lack of coordination of approaches to addressing the issues involved. We would be very happy to contribute to the formation of a comprehensive, coordinated and well integrated plan which would address the severe limitations of the present system to meet the mental health needs of all members of the Australian community. We sincerely hope that the Committee provides such a framework.

Dr Don Pritchard MA, (1968) PhD (1986)

Former:

Chief Clinical Psychologist (SA Mental Health Services),
Senior Clinical Lecturer, University of Adelaide
Top Grade Chartered Clinical Psychologist Wessex Health Trust, UK
Principal Chartered Psychologist, Aylesbury Mental Health Trust, UK

Elizabeth Salna	**BA (Hons) M. Psych (Clin) (1974)**
Franklin McCurdy	**BA (Hons) M. Psych (1977)**
Jan Harry	**BA (Hons) M.Appl Psych (1996)**
Lisbeth Kunst	**BA Hons M.Psych (Clin) (1976)**
Dr Daryl P Hansen	**BA, Dip App Psych, Grad Dip Psych Prac, M Soc Sc, D Psych (4 yr Clin).**
Dr Mark Cescato	**BA Dip Ed, Dip App Psych, M Psych, PhD**