

03/08/11

Senate Committee on Mental Health Funding, 2011 Personal Submission

Re: the government's intention to cut funding for the so-far successful Better Access to Mental Health scheme.

1. There is much funding directed to **suicide prevention** in theory, however the majority of people reporting to feel suicidal are likely to be practically serviced by a GP, Psychologist, or other Allied Health worker. Having worked in the Mental Health Services of Qld Health for 20 years, I have observed that Mental Health only have funding for maintaining the severely chronic mentally ill such as Schizophrenia and Bipolar Affective Disorder. More recently (say 6 years ago) Accute Care branches of Mental Health have been formed to "service" these people in person for a one-off assessment in Accident and Emergency after an actual suicide attempt, and/or by phone for a few days. The real purpose of these brief interventions is to keep suicidal clients off the books of Mental Health. It is to check if they are **safe**, not to **treat** the client and provide routine therapy sessions which may teach/ retrain the client how to respond differently to the circumstances that caused the suicidal state to arise. Up to say 10 % of my client load report suicidal symptoms which usually abate within 6 to 12 sessions.

Borderline Personality Disorder is common, difficult to treat, most likely to be in the lower socio-economic range i.e. needing compassionate psychologists to provide them with a Bulk Billing service, need 18 sessions and unlikely to be given therapy at all in the Mental Health Institutions. When they self-harm they are stitched up in Accident & Emergency sent on their way and seen as a nuisance. It is only since the Better Outcomes scheme has been introduced that this gap in services to the general public has been addressed with any sincerity.

I believe the suicide rate will increase if the cap is to be only 10 sessions. I believe the number of psychologists in private practice will reduce, and/or cause well established Psychologists charge a gap to recoup losses. This means the second suicidal client group I refer to will further have reduced access to the needed care and be at risk.

2. The **in-house** term "**Endorsed**" psychologist is bestowed on a small percentage of Psychologists that have endeavoured (to their credit) to increase their training and education through formal channels giving them titles such as Masters and Ph.D and/or other training to be members of elite groups as defined by The Australian Psychological Society (APS). This highly reputable organisation has always encouraged and inspired all Psychologists to pursue continuing quality improvement which eventually became mandatory (for continuing membership) through a point system. Few would disagree with the impetus since it led the way for a very high standard of respect for the profession of psychology.

When Medicare funded psychologists through BOMC in November 2006 there was a higher level of rebate for the Endorsed psychologists. Up until that time the extra education/training was generally perceived by most psychologists as a **bonus**. I see nothing wrong with the extra reimbursement since it makes sound economics to recoup the

additional expense.

The problems as I see it are that:

(a) A name was needed to be given to those psychologists that have not been given the status of Endorsement by the APS, i.e. "**Generalist**" psychologist which in my opinion has associations of being mediocre or substandard. They could instead have chosen more respectful titles eg "Competent", "Qualified", "Nominated", "Graded", "Licenced", "Designated" Psychologist etc; given that the more appropriate term "**Clinical Psychologist**" had already been claimed by the APS for that group with more training and (in-house) status.

(b) There already existed other highly reputable Psychology associations that also made continuing professional development a priority. Since membership is expensive they may have represented psychologists just as competent as the APS Endorsed groups but were excluded from the higher Medicare rebate because Medicare arbitrarily selected the APS to be the only legitimate representing body. **Discrimination** therefore was introduced because of Medicare only accepted APS definitions. The APS in my opinion was already discriminating against psychologists with 4 year degrees (which was the norm at the time of my graduation in 1983) because there has not been acknowledgement of the hundreds of hours of additional training through workshops, individual supervision etc that psychologists of that generation received and were expected to receive. There also has been no attempt to quantify **experience** which I believe is a better predictor of competence than education. (I have 25 years of experience in clinical psychology.)

The perception that "generalist" psychologists were not as good as higher paid psychologists expanded as it required doctors to be the referring channel and thus participate in deciding the "best" source of treatment for their clients.

(c) Discrimination was exacerbated when the Psychology Board of Australia (which became a legal entity in 2010) not only accepted the definitions of the APS and Medicare but **extended** the perception of mediocrity of generalist psychologists by inventing the term "**unendorsed**" psychologists and closing the gate to well trained psychologists to gain "endorsement".

(d) The entire situation was politely excepted by the majority of dignified psychologists since there is no perfect solution and the system worked for the general public in need of care. The problem only became critical when Medicare decided to cut funding. That meant that there was not only a potential gross disservice to the public in need of psychology services but the very providers depending on Medicare support had to argue for survival.

3. Personal recommendations:

If the Senate Inquiry recommendations were to revise the current Medicare plan to cap psychology services at 10 sessions, planned to be implemented on 1st November 2011, I hope they ignore one suggestion put forward that the higher tiered psychologists should be given the additional status, funding and exclusive power to extend sessions to 18 for the mentally ill at the extreme end. Not only would it again exacerbate the discrimination against Generalist Psychologists (as outlined above) but it is not practical. Firstly there is not enough higher tiered psychologists to do the job. Secondly they are not distributed well enough to do justice to the proposed requirements. Thirdly it would be ineffective to launch a brand new treatment plan with another psychologist for a client that has reached their ceiling and is in need of more sessions. Forthly it is

unethical to force a client who has formed a good relationship with a generalist psychologist doing good work, into a new one with someone they may not get the same empathatic bond and who is becomming inaccessibile due to the newly created bottleneck.

Instead, may I suggest that if money had to be saved, that the higher tiered psychologists be paid at the same lower rate as generalist psychologists and the savings be forwarded to providing more that 10 sessions accross the board by all psychologists to service the mental health needs of the general public.

Yours faithfully,

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Psychologist.