

27/07/11

The Committee Secretary
Senate Standing Committees on Community Affairs
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To Whom It May Concern

We are a group of ten Clinical Psychologists who work in Private Practice in the Far North Queensland areas of Cairns and the Atherton Tablelands. While we applaud the Government's commitment to mental health care in Australia, we have concerns about the funding and administration of mental health services.

We would therefore like to make the following submission regarding several items contained within the Inquiry into Commonwealth Funding and Administration of Mental Health Services being conducted by the Senate Standing Committee on Community Affairs.

(b) Changes to the Better Access Initiative

(iii) Changes to the rebate structure for the preparation of Mental Health Care Plans by General Practitioners.

We are concerned at the announcement of reduced rebates for General Practitioners to undertake Mental Health Services. Since the implementation of the Better Access initiative, the majority of our patients have been referred by General Practitioners who had provided them with a Mental Health Care plan. This enabled us to provide Clinical Psychology services while retaining ongoing liaison and communication with the patient's normal treating doctor.

More recently, several local General Practitioners have informed us that it will no longer be cost-effective to provide Mental Health Care plans when the rebate is reduced. In Far North Queensland, and particularly our more rural areas, there are few other options for patients to obtain this service. Many General Practitioners are not accepting new patients, and our Community Mental Health systems are overloaded and understaffed. As few General Practitioners provide bulk-billed consultations, this results in very limited access to mental health services for the many Health Care Card holders in our area, including elderly patients, indigenous persons, patients with disabilities and low income earners.

(iv) Impact of changes to the number of allied mental health treatment services

The recent Budget proposed a reduction in session numbers under the Better Access Initiative from a possible 18 sessions per year to 10, with no provision for additional sessions under exceptional circumstances. General Practitioners in our area refer complex cases to Clinical Psychologists for treatment. There is absolutely no evidence from any research, either in Australia or overseas, that co-morbid, complex cases respond in a matter of 10 sessions. In fact, recent research conducted in Australia concluded that, "...consistent with other findings, a minimum benefit should be closer to 20 sessions" (Harnett et al, 2010).

We recently heard the Hon Mark Butler, Minister for Health and Ageing, state that the reason for the cutbacks to the Better Access Initiative is that it was servicing people who are more able to pay for treatment, and not the most disadvantaged members of our society. This has definitely not been our experience of the program in our area. Many of our clients have clearly stated that without the Better Access Initiative, they would not have been able to obtain much-needed treatment. Far North Queensland has a well-documented pattern of economic disadvantage, including a high proportion of people who are unemployed, elderly, on low incomes or from indigenous

backgrounds. These persons clearly cannot afford private health care, either to obtain a Mental Health Care plan or to fund Mental Health Services.

In addition, individuals with chronic mental health problems include those whose conditions have deteriorated over a number of years due to a lack of ongoing mental health intervention. Under the current Better Access Initiative, these persons can be seen on an ongoing basis approximately three weekly by Clinical Psychologists in private practice, at a minimal cost to the community and a reduction of the Health Care burden on the public system. With the reduction in session numbers to 10 per year, these individuals with chronic mental health problems will be deprived of the ongoing support and care they need.

If you must reduce the number of sessions, could you please consider retaining the current provision of 18 sessions for individuals who have health care cards so the most vulnerable do not suffer unduly.

(c) Impact and adequacy of services through the Access to Allied Psychological Services Programme

The Government has proposed that Services will be available for people with Mental Health needs through the Access to Allied Psychological Services (ATAPS) program. Our experience of the operation of this programme in our area raises serious concerns with this proposition.

The local ATAPS programme is currently administered through the Far North Queensland Rural Division of General Practice. Several Clinical Psychologists in private practice have been allocated funds to provide services to towns in Far North Queensland. They have concerns about the security of this programme, given that their services are often retained on a month by month basis, giving little ability to ensure patients of ongoing treatment. This funding is often withdrawn or changed without consultation, either with the Clinical Psychologists or the General Practitioners in each community. In other instances, the level of funding is insufficient to service the community the programme is intended to support. For example, the Clinical Psychologist servicing the Mareeba area under ATAPS is allocated eight hours per month to provide services through the two General Practices, Community Mental Health and the local Indigenous Health Service. This is particularly inadequate for a town of over 8000 people, with over 12 percent identifying as indigenous.

(d) Services available to people with severe mental illness and the co-ordination of these services

The Government has argued that persons with chronic mental illnesses and those on low incomes will be accepted by Government Mental Health Services. This is definitely not the case in Queensland, and not a viable option for many people in our area. Our local Government services are unable to accept clients unless they are deemed to have a 'serious mental illness', such as Bipolar Affective Disorder, Schizophrenia or Schizoaffective Disorder. Many do not meet the criteria for these already over-stretched Government Mental Health Services. Given their shortages of resources, local services are not able to accept clients with other complex or co-morbid presentations, including depressive disorders, anxiety disorders, personality disorders, substance abuse, chronic medical conditions, pain and sexual disorders. These clients now form the majority of the caseload for privately practicing Clinical Psychologists working within the Better Access Program in our area.

It has been proposed that individuals with a mental illness serious enough to require more than ten sessions per year can access treatment from a psychiatrist. There are no Psychiatrists located outside the Cairns region in the public health sector, or in private practice, of Far North Queensland, with regional and rural areas relying on a very limited programme of visiting Psychiatrists and Psychiatric registrars. For the few patients with private health insurance or higher incomes, there are already lengthy waiting periods for small number of Psychiatrists in private practice in Cairns. Furthermore, the majority of patients simply cannot afford ongoing therapy at the considerably higher fees charged by private Psychiatrists. Therefore, we have grave concerns that a large number of people who require ongoing therapy will be unable to access mental health services in our area should the proposed changes to the Better Access Initiative proceed.

(e) Mental Health Workforce Issues

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

We believe that the two-tier Medicare rebate system currently in place is legitimate and should be maintained. Clinical Psychologists have undertaken an extra two to four years' full-time study at university in order to develop the high level of skill needed to provide intervention to individuals with complex, co-morbid mental illnesses. As we work closely with the General Practitioners in our area, they are aware of the assessment and therapeutic skills of

Clinical Psychologists in comparison to generalist Psychologists, and specifically select the 'best fit' for their patients' needs.

Just as General Practitioners and Medical Specialists have the same undergraduate medical degree, similarly registered Psychologists and Clinical Psychologists have the same four year undergraduate degree. This undergraduate degree provides a broad understanding of human behaviour and research techniques. The formal academic training to become a registered Psychologist stops at this point. Graduates enter the workforce as an intern Psychologist and are required to complete a supervision program which includes discussing their cases with a registered Psychologist for one hour per week for a two year period. In contrast, Clinical Psychologists complete a rigorous post-graduate degree in Clinical Psychology which typically takes two to four years to complete. In addition to the formal academic requirements, this training also involves a minimum of 1000 hours of clinical placements working with very diverse client groups and age ranges under the supervision of experienced Clinical Psychologists. The emphasis of this practical component of the training is on clinical assessment, diagnosis and treatment of complex presentations. This specialist training provides Clinical Psychologists with a high level of understanding of assessment, diagnosis and treatment of a broad range of complex mental health problems.

Registered Psychologists can make a valuable contribution to the treatment of mental health issues. However, they lack formal academic training in working with complex clinical presentations. This additional training cannot be attained by attending day workshops.

It is relevant that the Australian Psychological Society supports the two-tier Medicare rebate system. Given that 80 percent of the members of the Society are generalists, and only 10 percent are Clinical Psychologists, the executive must be secure in its appraisal of the situation. There could be no more informed body than the Society to make such an evaluation.

(e) Other related matters

We live and work in Far North Queensland, where access to many health services falls well below that experienced in major towns and cities. The difficulty of attracting and retaining specialist staff to these areas is well known. The difficulty of accessing Mental Health Services in rural areas is similarly evident. Under the existing Medicare system, our group of Clinical Psychologists have been able to provide Mental Health Services to people living in our area, including many isolated and disadvantaged groups. Our services to these patients are frequently bulk-billed. We have done this while working closely with General Practitioners, and have been well satisfied with our rate of remuneration and working conditions. We feel that we have provided a valued service to our communities, and take great satisfaction in what we have achieved. Many of us have worked under a number of government and non-government schemes and systems in past years. We have found the Better Access Initiative to have enabled the most workable and practical method of providing services to mental health patients, while ensuring communication with General Practitioners and a connection with our communities.

We are concerned that this situation will change dramatically with the proposed changes to Medicare. We fear that the viability of our practices will be compromised to the extent that we can no longer offer services to people living in our areas.

Therefore, we request that the existing system of funding for General Practitioners and Clinical Psychologists, and the annual allowance of 12 to 18 sessions per year, be retained. To change the existing system would result in many people currently receiving mental health services to be considerably disadvantaged.

We thank the Senate Committee Enquiry for considering this submission.

Signed

Jo Chibnall, Shelley Crawford, Mavis Derman, Ina Flockhart, Danae Owen, Chris Maltby (in absentia), Stacey Pickert, Lorraine Slaven, Gayle Sticher, Hugh Woolford

Signatures for the ten clinical psychologists listed above and the reference cited are on the following page

Reference

Harnett, P., O'Donovan, A., & Lambert, M.J.(2010). The dose response relationship in psychotherapy: Implications for social policy. *Clinical Psychologist*, 14,2,pp 39-44

Please Note: Chris Maltby is currently unavailable to sign but asked to be included.

List of signatories with their qualifications

Jo Chibnall,. B.Psych; MClInPsych; Member APS College of Clinical Psychologists

Shelley Crawford. B.Psych (Hons); DPsyCh Clin; Member APS College of Clinical Psychologists

Mavis Derman,. BSc; HONS BA (Psych); MA (Clin Psych); Member APS College of Clinical Psychologists

Ina Flockhart, B.Psych (Hons); DPsyCh Clin; Member APS College of Clinical Psychologists

Chris Maltby, Unable to verify - Member APS College of Clinical Psychologists

Danae Owen, B.Psych; MPsyCh (Clin); Member APS College of Clinical Psychologists

Stacey Pickert, B.Psych (Hons); MPsyCh (Clin); Member APS College of Clinical Psychologists

Lorraine Slaven, BA (Hons); MClInPsych; Member APS College of Clinical Psychologists

Gayle Sticher, BA (Hons); MClInPsych; PhD; Member APS College of Clinical Psychologists

Hugh Woolford. BScPsych (Hons); MClInPsych; Member APS College of Clinical Psychologists

Personal notes

Personal note from Jo Chibnall

On a personal note, I believed so firmly in the benefits of the additional education and training involved in obtaining a Master of Psychology (Clinical) degree, that I sold my home in order to stay at university for the three years that the postgraduate qualification took me to complete. It is a sacrifice that I do not regret, and I believe that I am a far better clinician for that training.

Whilst I have no doubt that there are many excellent generalist psychologists employed and self-employed in many areas of psychological practice, my belief in the difference in quality of training between the two avenues for registration was reinforced by my experience of supervising Master's students and provisionally registered psychologists under the Supervised Practice Program. I found a significant difference in knowledge and skill levels between the two streams, in terms of assessment and treatment of clinical problems. In my supervision work, I tried to redress the limited knowledge base and increase the clinical skill levels of provisionally registered psychologists, by holding group supervision training sessions with my supervisees. Thus, my experience of supervising both grades of supervisees confirms my belief that to treat more complex cases clinical training at Masters level is required.

Personal note from Hugh Woolford

I completed my undergraduate training in my late 30's from the University of New South Wales in 1984 and worked as a psychologist in a community health setting from January 1985. I was keen and enthusiastic with a wealth of life experience. I was fortunate that I could obtain good supervision from a variety of mainly Sydney-based psychologists but after 5 years I realised that I needed more advanced skills to ensure "I did no harm". I relocated to Brisbane with my young family in late 1989, and was one of the 10 from over 100 applicants to join the clinical programme in 1991 which I self-funded. This was the only clinical training programme operating in the state at that time. Having worked as a psychologist for 6 years before starting my clinical training, I find it surprising there is an argument not to recognise advanced skills and training. Other professions, from accountants to doctors, recognise specialist training with increased payments. It is not that increased training makes anybody superior, but better trained in a particular area. It is also important that there is some consistency in the degree of clinical training in Australia to that provided in other countries in the world: apart from New Zealand, Australia is the only country that does not have post graduate clinical training as a minimum standard to practice as a psychologist.