# Submission to the Senate Committee Affairs Committees: Government's Funding and Administration of Mental Health Services in Australia.

**Introduction**

I am a Psychologist that would be categorised as a 'Generalist'. I work in a private school one day a week and in a group private practice three days a week. I have included four appendices below. Appendix 1 outlines information that pertains to my work in the school. Appendices 2, 3 and 4 are case presentations of clients I have worked with in private practice, that I feel best represents some of the terms of reference that the Senate will be addressing. Cases presented below have changes made to protect client's identity. I administer the Depression Anxiety and Stress Scale (DASS) with all clients to monitor the efficacy of treatment, and assist clients to make connections between the stressors that occur in their life and the symptoms of depression, anxiety and stress that they experience. The DASS scoring falls into five categories of severity (normal, mild, moderate, severe and extreme). The normal range is the degree of symptoms of depression, anxiety and stress that would be expected in everyday life for individuals who do not suffer from mental health issues. NB: The range of scoring between categories for depression, anxiety and stress are not comparable. The advantage of the presentation of the DASS for the purposes of this submission, is that it provides the Senate with data that has been collected throughout each client's therapy process, and indicates the points of temporal change associated with therapy outcomes.

**Term of Reference (b) (ii): The rationalisation of allied health treatment sessions**

An individual's capacity to function in all areas of life is largely dependent upon their mental health and emotional well-being. Clients I have worked with have made significant gains in occupational functioning, academic functioning, relationship functioning, issues associated with family functioning (e.g., separation), issues associated with substance use, self-harming and issues associated with suicide. Whilst I recognise and acknowledge that Psychologists are placed in government agencies to assist with these types of issues, I have worked with many individuals who had already utilised in-house agency interventions, however, after entering a process with me in private practice and in the school I work, these individuals were then able to make changes. It is well acknowledged that the factor that highly influences interventions is the therapeutic alliance, and in private practice you are better placed to provide continuity of care and build a stronger alliance with clients. The cases presented in the Appendices, all evidence individuals achieving outcomes in various areas of functioning. I would like to note that the case in Appendix 4 is a good example of how these types of outcomes can reduce the expenditure and burden on other government departments (e.g., the court system). Not to mention the high probability that the child in this case is likely to benefit from a mental health perspective immediately and in the future.

**Term of Reference (b) (iv): The impact of changes to the number of allied mental health treatment services for patients with mild or moderate mental illness.**

Appendix 3 is a good example of an individual who experienced symptoms of depression, anxiety and stress, however would not be considered to be an individual to be suffering from a mental health disorder as prescribed by the DSM-IV TR. There are two issues that the current Medicare system does not service. First, there is a substantial body of evidence outlining issues associated with depression contagion. Secondly, there is also much empirical evidence highlighting the difficulties associated with care-giver burden. Although the client in Appendix 3 experienced mild to moderate symptoms, it is an example of a need for assistance for family members living with individuals with a severe mental health issues, and issues associated with depression contagion. This case also demonstrates that the number of sessions required was greater than the Medicare model prior to the changes that are being proposed (a 6 X 4 model).

**Term of Reference (d): Services available for people with severe mental illness**

Psychologists are required to adhere to a strict code of ethics prescribed by the APS and the Psychology Board of Australia. A section of the code of ethics emphasises that Psychologists are required to assist clients to gain skills in managing their life circumstances and stressors autonomously. I have led many clients through processes of termination of therapy. Therefore, the question I propose is: Why is there a cap on the amount of sessions for clients who are considered to have extenuating circumstances? The client in Appendix 2 is such a client, where this individual was emotionally not stable enough to work through the complex life issues that had precipitated and continued to trigger this clients fluctuating emotional journey. I ask that the Senate considers the need to increase the number of sessions required to assist individuals who have significant clinical presentations and are experiencing ongoing stressors, ongoing life circumstances, and/or are suffering from a comorbid condition that hinders the client's capacity to go through an earlier termination of therapy process.

Finally, my understanding is that under the changes to the Medicare process, clients in our care who require more sessions than a 6 X 4 model will require a Psychologist who is registered with a Medical Local. We have been advised by Metro North Brisbane Medical Locals that there is a waiting list for Psychologists who were not on the pre-existing scheme of GP Partners. My perspective is that this is an inequitable situation for Psychologists who will be placed on a waiting list. Furthermore, it places some clients who most require assistance at a disadvantage, if the Psychologist that they may have built a therapeutic alliance with, is on a waiting list to benefit from the extended Medicare assistance scheme.

**Term of Reference (e) (i): The two-tiered Medicare rebate system for psychologists**

There has been much debate as to whether Generalist Psychologists work with clients with significant clinical issues. As evidenced in Appendix 2, Generalists do work with cases that are clearly complex and clinical in nature, and do achieve significant positive outcomes. The case in Appendix 2 also gives support to the fact that Generalists have existing relationships within the health community, and work co-operatively with many specialists. I attend peer group supervision session once a month with a group of Psychologists, and in discussing this point it became apparent that as a group of Generalists we receive referrals and work co-operatively with: the Royal Brisbane Hospital, the Acute Care Team in Fortitude Valley, Sunnybank Obesity Centre, Disability Services, Workcover, Department of Veteran Affairs, Queensland University of Technology Health Services, Schools, General Practitioners, Psychiatrists, Paediatricians, Speech Therapists, Occupational Therapists, and Physiotherapists. Appendix 1 also evidences that Psychologists working in schools are often working with a broad range of clinical and severe cases. I add this point to emphasise that individuals experiencing significant clinical issues are encountered in a variety of contexts that the existing Medicare system does not service. Whilst I do refer students to other Psychologists, Psychiatrists and public mental health services, some individuals are resistant to enter a formal therapeutic process, and receive assistance within the school.

**Term of Reference (e) (ii): Workforce qualifications and training of psychologists**

The argument that Clinical Psychologists training is different to that of a Generalist is correct. However, the perspective that a Generalist receives an inferior model is questionable. I chose to do an internship as a Generalist and completed by full internship in private practice. When I first spoke to my supervisor for my internship, I stated that I wanted to complete a comprehensive internship and that my interests were not in coming to completion quickly. I completed my internship over a period of 4.5 years. A colleague came to me on completion of her Masters and expressed that she was experiencing anxiety in putting her knowledge into practice. In contrast, on completion of my internship I felt well supported and ready to work in private practice. I feel that the advantage I had from the process of my internship was gaining experience in taking numerous cases from intake to a termination of therapy processes in private practice whilst under supervision. Additionally, whilst I did not complete a Phd, I did complete two years of a Phd under the supervision of a Clinical Psychologist. I believe that one of my strengths in my practice has been a direct influence from the opportunities I had in presenting research with my Phd supervisor. I feel that the greatest impact on my practice stems from my learning and the how I think was heavily influenced through this process. I might add that I exited the Phd with a grade point average of 7. This leads to my next point. Not all learning can be accounted for by a degree or qualification.

I have *chosen* to be a Generalist and have undertaken more professional development than that is required, is APS endorsed and across topics such as: suicide intervention, PTSD, and Interpersonal Therapy for Depression. I have also broadened my knowledge base by buying text books prescribed in the Masters program. In the same way that I approached my internship, I approach my development as a Generalist to continue to acquire skills and knowledge, tailored to my clients needs

which includes complex, clinical cases. My position is that the experiences of the individual, regardless of the pathway they undertake, are idiosyncratic and different. Not necessarily inferior. In making decisions about the distribution of Medicare rebates I recommend that the Senate carefully considers that in Australia neither the Australian Psychological Society nor the Psychology Board of Australia segregates Psychologists in a dichotic fashion between Clinical Psychologists and Generalist Psychologists. I also feel that the Senate should consider whether the percentage of Clinical Psychologists in Australia are able to service the number of individuals requiring therapy, and if a two-tiered model would result in clients on waiting lists who are in desperate need of assistance.

**Term of Reference (j): Any other related matter**

In my experience the current referral process through General Practitioners in contrast to the referral process through Psychiatrists have highlighted that the current Medicare system is somewhat unnecessarily complicated. I took the time to complete the online learning modules to assist me in understanding and adhering to the Medicare process. Unfortunately, I do not feel that the online learning modules prepared me for the difficulties I have experienced since. The most significant outcome is that the difficulties have often interfered with continuity of care for clients. The timeframe for a Psychologist to write a report and then for the client to get an appointment with their GP for an extended consultation to meet the requirements of the current Medicare referral process within one week is particularly stressful. Especially for clients who require ongoing weekly sessions. I find the process of referrals through Psychiatrists (in the form of a letter), a process that facilitates the Medicare process with greater ease and often far more achievable.

Another ongoing difficulty is the different interpretations held about the referral process. The two most common difficulties are what constitutes a referral and what constitutes a calendar year. I get many different presentations of referrals from different GPs. In one case the practice manager from the practice where I work discussed this difficulty with another practice manager from a GP. They decided that they should both call Medicare and then call each other back to resolve the issue. After both practice managers had individually called Medicare, they came back with different outcomes, and the issue has continued. This could easily be remedied with a Medicare Manual that we can all access and have a common frame of reference, when sorting through these types of issues. Some GPs interpretation is that the calendar year is based on the date of the initial referral, with other GPs interpretation that a calendar year begins in January and finishes in December. We have been advised by Medicare that a calendar year is from 1st January to 31st December, however we continue to experience difficulties when other health professionals interpretation is different. This then raises issues associated with when a client qualifies for extenuating circumstances, as the number of sessions is put out of sync between the GPs and the Psychologists records when there is a difference of interpretation of what a calendar year constitutes. I am hopeful that the Senate will facilitate a resolution for this issue.