



Thursday 4th August 2011

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

Re: Senate Community Affairs Reference Committee Inquiry into Commonwealth Funding and Administration of Mental Health Services

As a Clinical Psychologist living and working in a Rural and Remote location, in both the public and private sector, I will address the Terms of Reference for this Inquiry that have specific application to my community. Whilst I applaud the increased expenditure in the provision of services within the Public Health Sector, through increased access to Psychiatrists, and the roll out of Head Space and EPPIC Centres, they are unlikely to be felt in Rural and Remote Communities, and are not consistent with workforce projections for Psychiatrists. I am concerned that the proposed changes will actually result in decreased accessibility to services for individuals, particularly children and adults with Moderate to Severe Mental Illness, or more complex presentations, particularly in Rural and Remote Areas that are being serviced by Psychologists working in the private sector. The threat to reduce the two-tiered Medicare rebate system for Psychologists is also likely to have negative implications for service provision in Rural and Remote Areas, higher gap payments for clients and difficulty attracting and retaining skilled clinicians in hard to service locations.

There have been many well written submissions with strong research evidence submitted by my professional peers, that have addressed the main issues in relation to the reduction of rebated Medicare sessions under the Better Access Initiative, and the potential implications for treatment outcome for clients with Moderate to Severe Mental Illness, or complex case presentations. Also, the expectation for Psychologists to be able to deliver effective treatment to clients in 6 – 10 sessions, when there is a sufficient and rigorously tested research base to indicate that an effective course of treatment is 12 – 20 sessions for moderate presentations, and often longer for more severe cases, and what both the ethical and treatment implications are likely to be around this. For this reason, I will be choosing to focus upon what the impacts of the reduction in session number from 12 – 10, and also the withdrawal of the

Exceptional Circumstances are likely to be in a Rural and Remote Community, particularly for children with Moderate to Severe presentations who do not have ongoing access to a service in the community, other than through a private psychologist.

Background

By way of qualification I have a Bachelor of Arts (Honours) and a Master of Psychology (Clinical), and I have also undertaken a formal period of Clinical Supervision. I am a Member of the APS, and more recently a Member of the Clinical College of the APS. I have worked hard for my qualifications and to achieve my professional membership, and am proud of my occupation and consider myself privileged to undertake the work that I do. I have worked as a Generalist Psychologist, whilst completing my Clinical Masters and have written my Masters Thesis and undertaken Clinical Supervision from a Remote Location, involving many hours of travel, time away from family and work and significant financial expense in order to attain my qualifications. This is without regret, as I utilize my additional clinical skills every day, and in turn this is of benefit to my clients and the community in which I live. It is also an important part of how I manage the pressures of living and working in a Remote Community as a professional. I had considered submitting this submission anonymously, however I would like the Senate Committee to consider the wideranging impact of broad based policy application to rural and remote communities, and my work situation is a potential illustration of this.

I live and work on Kangaroo Island, South Australia, and am the only Psychologist living and working on the Island and providing an ongoing service to the local community. Kangaroo Island has a resident population of 4500, with a predominant agricultural and tourism industry, and over 160 000 tourists visiting each year. I established a Private Practice on the Island 4 years ago and more recently also work within the public health sector on the Island in a Multi-disciplinary Adult Mental Health Team. Within my private practice I work with children, adults and families, and provide the only child **on Island** service in Mental Health (ie not a visiting service). I am the only Psychologist providing ongoing service on the Island.

I work closely and in conjunction with the GP's, Mental Health Team, DECS, Disability SA and visiting services, such as CAMHS and Medical Specialists, and other referral agencies. Within Country Communities where resources are limited, and onward referral services are not available mental health systems and health systems learn to "make do", and focus on making things work in terms of providing outcomes for consumers. This means regular communication, collaboration between services, and a significant amount of time out of hours in ensuring best outcomes for clients and their families, where crisis supports and onward referral options are limited, or more often non-existent without heading off Island.

1. Changes to the Better Access Initiative, including: Rationalization of Allied Health Treatment Sessions; The Impact of Changes to the Number of Allied Mental Health Treatment Services for Patients with a Mild or Moderate Mental Illness under the Medicare Benefits Schedule

The Federal Budget has reduced session numbers from a 6+6(+6) model to a 6+4 model for clients referred under the Better Access initiative to Psychologists. The implications this is likely to have in terms of service provision and evidence based practice, and most importantly outcomes for clients with a Moderate to Severe Mental Illness are significant. Assurances around increased expenditure in relation to Public Mental Health Services are a significant boost, and well overdue for Australia, however it is of concern that this is coming at a potential cost to access to services with highly skilled Clinicians, with the majority of Psychologists now employed within the Private Sector. Many Clinical Psychologists, who are specifically trained and with specialist skills to work with the most severe and complex presentations work in the private sector, providing services to clients referred under Better Access. Reducing access to Clinicians is likely to have significant negative outcomes for clients and the community, particularly in Rural Communities who do not have the population base to benefit from any real increased expenditure in other areas. According to the National Rural Health Alliance (NRHA) whilst reported prevalence of Mental Illness is comparable to major cities, there is a significant lack of available treatment options and thus options for early intervention are limited or not available, resulting in higher levels of chronic mental illness and other associated illness. The AIHW reports that rates of completed suicide in regional and remote areas are 1.2 to 2.4 times higher than those in major cities (<http://nrha.ruralhealth.org.au/cms/uploads/factsheets/fact-sheet-18-mental-health.pdf>). It is therefore of significant concern to look at broad based application of policy to smaller communities and how this translates into actual service provision.

Kangaroo Island is a good example of this, in that the implementation of the changes as a result of the Rationalisation of Medicare Funded sessions will mean that children under 12 years of age, with moderate to severe issues who require more than 10 sessions and are currently being referred to me privately will have the only other on Island option, which is a 4-weekly visiting service through CAMHS, which already has extensive wait lists. Under the ATAPS system, children under 12 years of age or with behavioural issues are not to be referred. As a Clinician I work closely with the visiting services, including CAMHS, and together we work to best support clients and provide positive outcomes, however visiting services are very limited in terms of the intensity of support that they provide, and have to work differently than they would in a metropolitan location. At times, this means that I am referred clients privately who have been working with CAMHS, but need a more intensive support than they are able to provide with a visiting service.

Recommendation: That Clinical Psychologists working in Rural and Remote Locations, or other underserviced areas, are given the authority to apply for an extension of service provision for clients presenting with Moderate to Severe Issues, who require more ongoing or intensive support. This could be done through liaison with the GP or treating Psychiatrist. Determination of remoteness could be done through the application of Australian Standard Geographical Classification Remoteness Areas (ASGC-RA).

2. The Impact and Adequacy of Services Provided to People with Mental Illness through the Access to Allied Psychological Services Program

As stated above, the ATAPS Program does not service children under 12 years or those with behavioural issues. Furthermore, the qualifications required in order to be an ATAPS provider are not as rigorous as those required under the current Specialist Provider of Psychological Services through Better Access. ATAPS Providers can include Psychologists, Mental Health Nurses, Occupational Therapists and Social Workers, with the premise being “training in CBT”. With the exception of Psychology these are generally 3 – 4 year undergraduate degrees, that do not require formal clinical supervision, or have the same rigorous Professional Development requirements that Psychologists are required to meet. Therefore the changes under the Federal Budget are directing people with more complex and severe presentations **potentially** towards clinicians with less formal training or recognition of their qualifications.

Recommendation: That Clinical Psychologists who have undergone assessment with the APS Medicare Panel as Specialist Clinical Psychology Providers have provisions made so that clients are able to continue to access up to 18 sessions under the Better Access scheme, ensuring continuity of care from Treatment Providers and maintenance of high levels of training, as well as ongoing Professional Development skills, when seeking out treatment for Moderate to Severe Mental Illnesses.

3. Mental Health Workforce Issues, Including: the Two-Tiered Medicare Rebate System for Psychologists, Workforce Qualifications and Training of Psychologists, and Workforce Shortages.

The review of the two-tiered Medicare Rebate System for Psychologists, with a view to reducing the Specialist Clinical Psychology Rebate reflects an alarming lack of awareness of the contribution that the profession of Clinical Psychology has made and continues to make to Mental Health and Wellbeing, in both research and practice. Again, this has been very well documented by my peers, however, I do wish to state that given the rigorous review of Psychology, Clinical Psychology and the 8 other fields of Psychology Specialisation recognised by AHPRA and the PBA leading up to and during the transition to National Registration, the current review of the two-tier system seems incongruent. At a time when professional standards are becoming increasingly rigorous, both to gain and then maintain, as a Clinical Psychologist it is easy to feel “under siege” professionally. Given the considerable cost, both financially and in terms of time, to travel and attend professional development courses and training, as well as peer supervision, and the logging of activities, and with many psychologists working in private practice, a potential reduction in Medicare rebates will impact upon clinicians as well as clients, in relation to gap payments.

As a Psychologist, living and working in a rural location with a low socio-economic demographic, I choose to bulk bill many of my clients, however, the costs of running a practice are higher in relation to travel, freight, and cost of living. An example of this is for a 1 day training event I attend in Adelaide I

have the additional cost of 1-2 nights accommodation, an 8 hour round trip by ferry and car, and a cost of approximately \$200 to get on the ferry, as well as petrol. On top of this I lose an additional day of work time due to travel. Not only does this result in loss of income, it also increases the pressure of waiting lists. Unlike Medical Specialists, no rebates are available for Allied Health Providers in private practice to service Rural and Remote populations. Reducing the two-tier Medicare rebate system to a lower rebate will have implications for Clinical Psychologists who are already working in hard to service areas, such as Remote locations or locations with complex needs and lower SES, by decreasing the viability of their practice.

Psychologists in private practice already put in a significant number of hours away from the client, in order to service client needs. This is through writing letters back to referring specialists, phone calls and/ or meetings with family members, other service providers, as well as preparing for sessions. By reducing the Medicare Rebate potential impacts include, increasing the number of client contacts to maintain income, thus decreasing time available for work away from the client; increasing gap payments (the Medicare rebate is already well below the recommended APS fee); devaluing Clinical Psychology and Psychology in general as a profession (why would anyone undertake a minimum 8 years of Study and Clinical Supervision when you get paid the same for 4?); and disenchanted professionals looking to move out of the profession.

Recommendation: I strongly urge the Committee to retain the two-tiered Medicare Rebate System for Psychologists. Continuing to maintain the recognition of Clinical Psychology as a Specialist Field of Psychology is in accordance with international standards, and a positive step towards recognition of the other Endorsed Areas of Psychological Specialisation under Medicare.

4. The Adequacy of Mental Health Funding and Services for Disadvantaged Groups, including: 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.

Anything that is done to increase access to services for people with a Mental Illness, living in Rural and Remote locations and hard to reach groups can only be a positive for the community. However, online and telephone based services do not replace the therapeutic relationship that is part of face-to-face contact. There has been recognition of the need to support rural placements for GP's and initiatives to attract Medical Professionals to Remote Communities, and there is ample evidence to suggest that a similar move would be positive for Australian Rural and Remote Communities through Psychology. Working in Remote Communities provides a richness in diversity of experience for Clinicians, as well as having to learn the ability to network and importantly awareness of professional limitations. Through increasing mental health funding and developing training initiatives in Rural and Remote Communities, it would both serve to increase service availability in traditionally under-resourced communities and with disadvantaged groups, as well as potentially providing an avenue through the provision of paid (or at least supported) Clinical Internships within Psychology, thus addressing mental health workforce issues now and in the future.

Recommendation: Online Services in Rural and Remote Communities provide an option, but should not be seen as an alternative to increasing funding to seek to attract and maintain Skilled Professionals in Mental Health to Remote locations.

Thankyou for your consideration. Please feel free to contact me for clarification or additional information.

Yours Sincerely,

Tamsin Wendt

BA (Hons) MPsych (Clin) MAPS