

29th July 2011

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

Re: Committee Hearing to occur 16/08/11,

To the Senate Community Affairs Reference Committee inquiry into Commonwealth Funding and Administration of Mental Health Services,

This document is tendered pursuant to notice of motion referred to the Community Affairs References Committee for inquiry and report by 16 August 2011 with respect to Government's funding and administration of mental health services in Australia.

It includes reference to the following matters, to which I wish to express my concerns and provide my own recommendations as a clinician in the community. In terms of my professional background, I am a clinical psychologist who has been working for mental health services since 2006, and across both private and public mental health services since 2008. As such, I have a good knowledge of the services available to consumers and the challenges faced in receiving appropriate mental health care in South Australia.

I have been made aware that the Committee is due to review the Government's 2011-12 Budget changes relating to mental health with specific reference to:

- (i) the rationalisation of general practitioner (GP) mental health services,*
- (ii) the rationalisation of allied health treatment sessions,*
- (iii) the impact of changes to the Medicare rebates and the two-tiered rebate structure for clinical assessment and preparation of a care plan by GPs, and*
- iv) the impact if changes to the to the number of allied mental health treatment services for patients with mild or moderate mental illness under the Medicare Benefits Schedule:*

Please find my response and recommendations to the aforementioned:

- i) The Better Access to Mental Health Initiative has proven to be a highly successful program that has enabled up to 2 million Australian's receive specialist mental health care whilst reducing the demands on public mental health services. As you are likely aware, the key findings of the Better Access Evaluation included:

- Over 2 million Australians accessed over 11 million psychological services during the 3 year period of the evaluation. Demonstrating a large community demand for such services.
- Eighty percent of Better Access consumers reported high or very high levels of psychological distress mostly associated with affective, anxiety and substance abuse disorders. Indicating that the services are being utilised by consumers with high levels of psychological distress – not just the ‘worried well’ as often misperceived.
- The services received seemed to be providing positive outcomes with the consumers’ symptoms reducing from moderate to severe levels of distress, to mild to normal ranges.
- The program seems to be cost-effective with the average package of care costing \$753, as well as the added benefit of reducing hospital admissions and emergency department presentations.

In general, these findings are consistent with my clinical experience. The success of this program indicates to me that it should be expanded to be more accommodating to those with severe and chronic mental health conditions, not dismantled.

ii) The recommendation that the majority of consumers can be treated in under 10 therapy sessions, and thus the number of sessions available should be reduced is misinformed and misleading. I provide private practice services in the Northern region of Adelaide which falls in the catchment of a number of low socioeconomic suburbs. The majority of referrals that I receive are for consumers with chronic mental health conditions, and complicated social circumstances (i.e. domestic violence, poverty, homelessness, transgenerational trauma, child protection issues etc.) which require more than 10 therapy sessions to gain successful outcomes.

These consumers are often not deemed ‘unwell’ enough to gain access to mental health services, and other services are simply not available or have long waiting lists. In fact, many of the referrals I receive are because Mental Health Services, Centrelink, Families SA etc. do not have specialist therapy services available or are overwhelmed with their own referrals. Furthermore, I provide bulkbilled sessions to these consumers as many are not able to afford to pay a gap due to long-term unemployment and/or reliance on government benefits. As such, I often see some of the most intense and difficult (but not impossible) to treat therapy clients, with significantly less financial reimbursement.

In my opinion, Better Access should be expanded to provide greater opportunity for the most disadvantaged consumers to receive specialist care. For example, providing a higher rebate and greater number of sessions under Better Access (i.e. up to 26 sessions a year allowing fortnightly therapy sessions over a 12 month period) for consumers who

are long-term unemployed, are on a Disability Support Pension, and/ or have a diagnosis of chronic mental illness (i.e. psychotic-spectrum disorders, complex trauma, personality disorders, eating disorders etc). This would enable the consumers most in need to gain access to specialist services without long waiting lists or out-of-pocket expenses. It would also provide more experienced clinician's greater incentive to work with these populations, and reduce the burden on the public mental health systems.

iii) No comment.

iv) With regards to the impact on services for those with mild to moderate symptoms of mental illness, if these symptoms can be treated within ten therapy sessions, it is unlikely that their service will be impacted. My concern is that funding is being removed from those with more severe presentations in which evidence-based treatments require more than ten therapy sessions.

c) The impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program;

Although, the government should be commended for increasing funding to services such as ATAPS, I am not confident of how effective this will be in practice. For example, I am not aware of where my local ATAPS program is located, the number of psychologists employed, and waiting lists for these programs. The Australian Psychological Society (APS) estimated that up to 86,000 consumers require more than ten therapy sessions in a single year. Do the ATAPS services have enough capacity to fulfil this need? How many clinical psychologists would be employed by the service? How would the program attract more experienced therapists?

I have heard that the financial reimbursement for working for such programs is significantly less attractive than establishing an independent private practice for experienced psychologists. My fear would be that more junior psychologists are employed in such positions and therefore consumers do not have access to more experienced clinicians who are trained to work with consumers with complex and chronic mental health problems.

In my opinion, these services would need to set up large teams of highly experienced psychologists who are provided with significant financial incentive, funded professional development and opportunities for career progression, if this is going to be a viable option.

d) Services available for people with severe mental illness and the coordination of those services:

Please note comments at point a, ii). However, to provide a case example I would like to express my concerns more specifically about how the proposed cuts will impact the treatment options available to individuals with a diagnosis of Borderline Personality Disorder. This population represent consumers who are often referred to my service and would be classified as experiencing very

'severe' levels of psychological distress. This group are also most likely to present to mental health services in crisis and are at high risk of life threatening behaviours including completed suicide. The recommended evidence-based treatment for this disorder is Dialectical Behaviour Therapy (DBT) which is an intensive program that requires consumers to attend 12 months of weekly individual therapy as well as attendance at weekly DBT skills training groups. These programs have been shown to significantly reduce self-harming behaviours in this population as well as save mental health services significant financial costs by reducing hospital admissions and crisis presentations to emergency departments.

In South Australia, the public mental health service does not have the number of trained clinicians or resources to provide this optimum level of treatment to BPD consumers in our state. However, we have found an effective alternative in which our local mental health services provide DBT skills training groups throughout the year, and consumers' access private therapists in under the Better Access Initiative. To date, this has been possible with the ability to extend the number of Better Access sessions from 12 to a possible 18 sessions each year. This number of sessions is sufficient (although not ideal) to see a consumer with BPD through a 6 month program. However, if Medicare funded sessions are cut down to a maximum of 10 appointments with no extension in exceptional circumstances, this will leave the majority of these consumers with out individual therapists. It is likely that this burden will fall back onto GPs, hospital emergency departments and the Mental Health System. In fact, I have already had to turn away one consumer as I would not have been able to ethically provide an effective therapy program in less than 10 sessions.

My fear is that is those who are in most need of specialist psychology services, who will not be able to access them – and as such the program would go from being 'Better Access' to 'Limited Access'.

- a) *Mental Health Work force issues, including:*
- i. *the two –tiered Medicare rebate system for psychologists.*
 - ii. *workforce qualifications and training of psychologists, and*
 - iii. *workforce shortages*

i) In my opinion, a two-tiered Medicare rebate system is useful in acknowledging the different levels of expertise and post-graduate training amongst clinicians. For example, clinical psychologists have completed a minimum of 6 years tertiary training. In addition, to become a member of the College of Clinical Psychologists, clinicians must meet the following criteria:

- An accredited Doctorate degree in clinical psychology followed by a minimum one year full-time equivalent supervised practice; OR
- An accredited Masters degree (or combined PhD/Masters) in clinical psychology, followed by a minimum of two years of supervised practice.

This equates to a minimum of 8 years training, plus ongoing professional development (mandated and monitored by APRHA) to maintain registration as a Clinical Psychologist. In addition to this, many clinicians are now extending their expertise to gain doctorates which extend their studies by a number of years. Comparatively, some registered psychologists need only to have completed 4 years of tertiary training and two years of placement in the field.

I do not believe that a single Medicare rebate system would be sufficient to acknowledge the vast differences in qualifications amongst psychologists. Rather, I think that this would inhibit career progression and specialisation of skills. Why would anyone study for 6 + years when they could be in the field earning an income after 4 years with supervised experience? On the other hand, there are many registered psychologists who trained through the 4+2 systems but have many years (sometimes decades) of clinical experience and professional development. Processes should be flexible enough to assist these clinicians to be recognised as 'specialist' Psychologists and they should be reimbursed accordingly.

In summary, I believe that a tiered rebate system should be maintained and even improved, to better reflect the qualifications and experience of clinicians in the psychological community. In particular, systems should be reviewed to ensure that highly experienced 'registered psychologists' are able to also have their specialist skills recognised under the scheme.

ii) As an additional point, many of my colleagues would argue that the current rebates are actually undervaluing the services and expertise provided by psychologists and that they should be increased. For example, the Australian Psychological Society (APS) currently recommends \$218 as the fee for a 45-60 minute consultation regardless of 'specialist title'. This is clearly much higher than the current rebate of \$119.80. In addition, it should be noted that for every client consultation there is estimated to be an hour of documentation, such as letter writing and phone calls which is often mandated (i.e. GP reports) but not reimbursed. Furthermore, this fee also needs to account for the costs of running a private practice (i.e. room rental, administration costs, etc). Based on these figures, the hourly rate of payment to a psychologist could in fact be considered to be less than half of this fee which is hardly representative of the level of qualifications that is required to work in this profession.

I recommend that the rebates under Medicare system actually be increased to better reflect the levels of qualifications and expertise required to work within this profession. This may also involve providing Medicare Items to cover time spent writing the mandated 6 session reports to GPs. It seems inequitable that GPs are reimbursed for writing their letters but that specialist clinicians are expected to do this without payment for time. Similar rebates could be applied to the increasing demand for psychologists to complete reports for Centrelink and other organisations.

iii) As a clinician who works in both the public service and private practice, the future for psychologists in mental health is looking pessimistically dim. As the Better Access Initiative improved the career prospects for psychologists, many of my colleagues reduced their employment with government mental health services in favour of private practice. The reasons for leaving mental health services included frustration at the lack of career progression, inequitable income in light of training and experience, lack of recognition of specialist skills, failure to provide private practice rights, and poor morale. I feel that cuts to Medicare will once again intensify these frustrations. Furthermore, as our mental health services go through reforms which threaten to further generalise the roles of psychologists away from providing specialist assessment and therapy services, towards a model of 'care coordination', it has left many clinicians anxious about what the future holds for psychology, with some even considering alternate career paths.

The flow on effect would of course impact the Universities as there is reduced incentive to study so extensively in the field of psychology if there are limited career prospects. However, ultimately, it is the consumers and the community who will be disadvantaged as they will be unable to access the evidence-based treatments that will alleviate their suffering.

In summary, I believe that cuts to the Better Access program will negatively impact on the psychology work force. Furthermore, work place issues also need to be addressed within government mental health services to improve the morale of the psychology workforce through the development of appropriate career pathways, fair and equitable income structure, establishment of private practice rights, and protection of 'specialist skills'.

f) the mental health funding and services for disadvantaged groups, including:

- i. culturally and linguistically diverse communities*
- ii. Indigenous communities, and*
- iii. people with disabilities;*

As mentioned previously, disadvantaged groups are more likely to present with more complex and chronic difficulties which are likely to require more than ten therapy sessions under the Better Access Program. Reducing the number of sessions available is likely to further disadvantage these populations.

g) the delivery of a national mental health commission

No comment

h) the impact of online services for people with mental illness, with particularly with regard to those living in rural and remote locations and other hard to reach groups; and

The development of such services seems to be a good way of improving access to remote and rural populations. Once again, private practitioners could be supported to provide such services but considerations would need to be made regarding access to appropriate equipment, confidentiality issues, policing who is providing such services via this medium (i.e. qualified and registered professionals) and so forth.

j) any other related matter.

No comment.

I hope that this document is accepted by the committee and discussed. I believe that this is a serious social issue which is likely to affect each and every Australian at some point in their lives. Mental illness knows no boundaries in the individuals that suffer and has a significant impact on loved ones and the broader community. Having discussions such as this brings mental health issues into the public forum and reduces the stigma that can prevent people from getting the help that could very well save their lives. It is our job as clinicians and decision-makers, to ensure that evidence-based treatments are available in the community to be accessed by ALL Australians who need them.

Kind Regards,

Clinical Psychologist, MAPS