SUBMISSION TO ENQUIRY ON COMMONWEALTH FUNDING AND ADMINISTRATION OF MENTAL HEALTH SERVIES

I am a clinical psychologist in full time private practice who lives and works in an outer suburb of Melbourne. My practice is located in an area encompassing both outer suburban and semi rural locales. I wish to make a submission which relates to several parts of your enquiry.

Reduction of Better Access sessions

I am very concerned about the Budget proposal to cap the maximum number of sessions available to people who access a psychologist under the Better Access to Mental Health Care at a maximum of 10 sessions, and about the suggestion that the two tiered Medicare rebate system for psychologists may be changed.

In relation to the issue of the number of Better Access sessions available each year, I note that most of my clients will not be affected by this, but for the minority who have severe and distressing mental health care issues, the previously available 12 - 18 sessions offered them a much better prospect of improvement in their functioning. For the most part these are clients on a DSP, who have complex and chronic issues. Examples are the clients with complex PTSD, or have co-morbid conditions such as severe anxiety/depression along with another diagnosis such as an autism spectrum disorder. In my practice they are bulk billed or seen at significantly reduced concessional fees and they would have no prospect of supplementing privately any additional sessions beyond those eligible for a Medicare rebate.

Clients with complex needs

During the calendar year of 2010 in my practice there would be about 10 clients who received 13-18 sessions of treatment; the many dozens of other clients attended and obtained the desired outcomes in the average 6-10 sessions. It is my understanding that the recent independent enquiry supports the view that the lower number of sessions is adequate for most. However the interpretation made by some that there would therefore be significant savings by reducing the number of sessions does not fit with the finding that only a minority in fact use more than 10- 12 sessions.

Along with many of my colleagues, I do not think it is fair to take such a tough stance on people who are already struggling with severe psychological distress. This proposal applies pressure to both clients and the psychologists they consult with, to achieve results over a very brief period of contact when the evidence available suggests that severe levels of symptomology will require more than 6 – 10 sessions of suitable clinical intervention. My concern is that this new policy will be frustrating for many people, who will simply give up.

ATAPS

I do not believe that after 10 sessions offering these disadvantaged clients access to other services such as ATAPS or Medicare Locals adequately recognizes the difficulty this presents for people having to obtain additional referrals to yet another practitioner and start again. Access to ATAPS schemes varies greatly, as does our capacity as practitioners to be a part of an ATAPS scheme. Ironically the very division that ultimately agreed to include me has several practitioners listed who do not work within its boundaries which means the idea that these clinicians are available in the region is quite illusory.

Some years ago I personally attempted to get listed with three local divisions (as my practice is across more than one location), because I was aware that the ATAPS scheme does provide some access to mental health services at little or no cost to clients who may otherwise have difficulty accessing mental health services. However I was hampered by delays and inconsistencies to the point where I only persisted with one division, and was only successful there after the bushfires in Victoria of 2009 revealed the paucity of suitably trained psychologists in the area who were listed with the division. My applications received varying responses of we do not need any more psychologists, we are only looking for psychologists to work with clients with certain specified conditions etc. One other division took more than six months to finally decide on my application with all the various exchanges that took place. The application was in their requested format, very detailed and time consuming to prepare, and then they insisted on a written examination type response on treatment protocols. This was to be "assessed" by a GP when I have post Master's level training in the area concerned along with multiple professional accreditations and was accredited as a clinical psychologist by Medicare. At that point I declined to pursue it any further.

The two tier rebate system

The division of general practice to which I do now belong has a mix of mental health professionals ranging from highly trained clinical psychologists to more broadly trained generalist psychologists. It has been my observation that the division staff and the doctors within it are not always aware of these differences. Clients with complex needs, such as those alluded to earlier, need treatment by clinicians with a high level of expertise in treating their particular mental health condition/s, and this would not generally be possible from a GP or a non-clinical psychologist. Even amongst highly trained clinicians, we do not all do "everything" and we are ethically bound to practise within our areas of expertise. For example, I do not work with adolescents but I do a lot of work with both children and adult clients with autism spectrum disorders, trauma and mood disorders. The more complex the client's needs, the greater care must be taken to ensure that the treatment provided is targeted and effective, which means that the clinician needs to know how to make variations from more general or standard treatment protocols. This is one of the core differences between the general psychologist and the clinical psychologist, and it is appropriately recognized as a difference which should be rebated accordingly. There **is** a difference between seeing a generalist and a specialist, there **is** a difference in their training and knowledge bases, there **is** a difference in their levels of expertise and it is reasonable for the specialist clinical psychologists to attract a higher rebate for their services because they are delivering a higher order of intervention.

(...)
Clinical Psychologist
(...)