Commonwealth Funding and Administration of Mental Health Services

Dear Senators,

Thank you for providing the opportunity to make a submission to the above Senate Committee inquiry. I would like to comment on two of the terms of reference this committee is addressing:

(b) changes to the Better Access Initiative:

> (iv) the impact of changes to the number of allied mental health treatment services for patients with mild or moderate mental illness under the Medicare Benefits Schedule;

and

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

I have read several of the submissions on the website and feel other clinical psychologists have extensively and eloquently covered other areas of significance in relation to the terms of reference including the two-tiered rebate structure, the ATAPS, and workforce qualifications and training of psychologists, so I will not repeat what has already been said in my submission. Suffice to say that there is good reason why a two-tiered system of rebates exists that is directly related to the training and qualifications of clinical psychologists compared with general psychologists.

Speaking as a clinical psychologist trained in Western Australian where there had been a clear pathway to achieving Specialist Title for over 30 years prior to the introduction of the Australian Health Practitioner Regulation Agency (AHPRA) in July 2010, the loss of Special Title has been a travesty of justice and a very bitter pill to swallow since the advent of AHPRA. Specialist title allowed the public to distinguish between general psychologists with four years of university education plus two years of supervision, and specialist psychologists, those trained for a further two (Masters) or three (Doctorate) years in a specialist area, followed by one or two years of supervision – eight years of training in all. Losing specialist title equates to a dropping of standards and fails to safeguard the public. The current terminology of "endorsement" is unclear and confusing for the general public and does not allow them to make an informed choice between practitioners.

(b) changes to the Better Access Initiative:

> ***(iv) the impact of changes to the number of allied mental health treatment services for patients with mild or moderate mental illness under the Medicare Benefits Schedule;***

There is clearly little understanding of mental illness by those making arbitrary decisions about the number of sessions that should be allocated to individuals suffering from mental illness. Reducing the current 12 sessions with the possible extension to 18 sessions in exceptional circumstances, to just six sessions with the possibility of 10 sessions, would disadvantage those with the most complex problems. It is true that **some** people with discrete, mild depression or anxiety **can** be helped with 10 or fewer sessions, however, in my experience, this type of patient is the exception rather than the rule.

I work in rural communities and most of my patients have complex mental health problems that have developed over time, often as the result of childhood abuse and/or neglect. There may be comorbid chronic medical problems, substance misuse, as well as personality issues. In addition, these chronically unwell individuals are more than likely to be on some kind of welfare benefit because their mental health problems preclude full-time employment.

There are few, if any, evidence-based therapies that can "fix" problems in fewer than 12 sessions, most therapies require 20 – 30 sessions, depending on the complexity of the presentation. You can't "fast-track" change and recovery. People do not respond well to change of any kind.

Treatment requires the patient to change long established cognitions and behaviours, and change takes time: consider if you have tried to change long standing habits of behaviour such as giving up smoking or giving up eating sugary food to reduce body fat – it is not easy! Changing patterns of behaviour and cognitions that negatively impact on mental health is exactly the same. It would be more logical and more importantly, ***ethical***, to **increase** the number of sessions that attract a Medicare rebate for patients with complex problems seeing clinical psychologists who are trained to treat such presentations.

Patients with chronic mental health problems are frequently the most disadvantaged in society because of their mental ill-health and their inability to hold down regular employment; they suffer financial stress as well. If the public mental health system is the only avenue of free assistance, they are forced to wait for lengthy periods to be seen by anyone, or else be in dire crisis to access the public mental health system. Having private practicing clinical psychologists fill this gap to meet some of their needs makes good, strategic sense. Reducing the number of Medicare rebated is both illogical and unethical: it leaves the complex patient "half-treated". How are they to cope when the 10 sessions run out? Ten sessions equate to less than one session per month. In all probability, it will cost the government more in the long term because if only surface problems are addressed in the 10 sessions, the deeper issues that perpetuate mental health problems have no chance of being addressed at all. This untenable situation would not arise if the patient presented with a physical/medical ailment: in that instance, there is no limit to the number of services they can access. Perhaps mental illness should be viewed in the same way as physical illness when individuals are accessing services provided by fully trained, clinical psychologists.

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

Whilst there is evidence to support the online treatment of mental illnesses, it should be noted that the bulk of these studies have used metropolitan patients; those living in rural or remote locations may not achieve the same results. I work in rural Tasmania and doubt that my most severely affected patients would have the capacity to work through online treatments. Some do not even have connection to the internet! In some locations, dial-up is the only service available.

Although the idea of using SKYPE is a good one, it is not appropriate for either dial-up or satellite internet services because of frequent drop-outs of service for no apparent reason. This is what happens here in Tasmania; it may be different in mainland Australia. Even in NBN ready Tasmania, the NBN will not service the entire state, thus online services should not be considered to be the panacea for all rural and remote locations.

Rural and remote Australia has an enormous problem attracting and retaining GPs, medical specialists and allied health practitioners. A possible incentive could be to offer higher Medicare rebates to those working in rural communities.

Thank you for providing this opportunity to submit these thoughts and opinions to the Senate Inquiry.

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2nd August 2011.