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

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I wish to make a submission to the above Senate Inquiry, in particular in reference to:

1) 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 (b)(iv), and,
2) the two-tiered Medicare rebate system for psychologists (e)(i).

Firstly, my interest in this hearing is as a solo private practice clinical psychologist working in the outer fringes of Melbourne in the 'mortgage belt'. I have been a registered psychologist 10 years. My practice bulk-bills approximately 50% of patients and the business hours are structured such that half the psychology sessions offered are outside normal business hours of 9am to 5pm. This is to enable greater access to mental health services for people who work during the day.

1) **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 (b)(iv).**

While the cuts to rebated session numbers in my experience will not affect most patients, no allowance seems to have been made under the new proposals for those with more *serious* pervasive, and overwhelming mental health conditions who are often in need of more sessions than those currently available (12-18 sessions per annum). Patients with serious mental health concerns are likely to be adversely affected under the newly proposed limit of 10 sessions per annum. In some cases this could result in a greater need of hospitalisation in public mental health beds (if available) at a cost much greater to the taxpayer than that associated with providing extra funds to consult a psychologist for some additional psychology consults.

Also, the ability to make significant improvements in patients' mental health status and in improving patient's self-management of their conditions, whether they are enduring a moderate or severe mental health condition, is likely to be reduced significantly for some patients if the number of potential sessions per annum is cut from 18 to 10.

The limitation on session numbers also does not apply to other mental health specialists, e.g., psychiatrists, so why the limit for clinical psychology? The limitation on sessions, be it 10, 12 or 18 per annum, means that some needy patients

eventually are next seen on a *wait-for-the-next-calendar-year* basis. As I write it is late July 2011, so anyone reaching their session limit by this time of the year, would have to expect a five month plus wait before they might access services again. I ask you 'How many other fields in the Australian health care system have a *wait-for-the-next-calendar-year* access policy?'

2) The two-tiered Medicare rebate system for psychologists (e)(i).

I write in support of maintaining the two tier medicare rebate system for psychologists. In medicine, a model of paying more for specialist doctors rather than generalists appears to go unchallenged. In psychology, it would now appear that psychologists whose training has been specifically in the area of assessment and treatment of mental health disorders (e.g., clinical psychologists) are having to justify their rebate premium over other psychologists whose training may have focused predominately in other areas (e.g., relationship counselling, neuropsychological testing, organisational psychology, general health psychology…) rather than an in depth study of mental health disorders, as is the case with clinical psychologists. It should be stressed the Better Access scheme is all about providing services for *mental health disorders* and that the clinical rebate premium recognises a *greater relevance* of clinical psychologists training to mental health issues as compared to non-clinical psychologists.

I ask you to consider, if you had a family member with a mental health disorder would you prefer that family member be sent to a mental health specialist (e.g., clinical psychologist) or would you be willing to send that family member to a practitioner whose training may have focused primarily in a non-mental health area?

This important distinction in psychologists' skills was recognised by my local state – Victoria – when I first started looking for employment in the public sector. The state in its job advertisements specifically requested wanting Clinical Psychologists (not general ones) for work in the mental health sector, as they recognised the extra relevance of clinical psychologists training for such positions.

Also, I ask you to consider that the distinction between clinical psychologists and mental health specialists, as compared to other streams of psychology, is recognised internationally. For Australia not to recognise this important distinction in psychology, and service provision, would be a backward step for the profession of psychology in this country in my opinion, and could put at risk the quality and delivery of mental health service provision received by Australians.

On a personal note, I am concerned that for a practice, such as mine, with such a high bulk-billing component, that if the medicare rebate was reduced, the financial viability of my practice would become marginal. Subsequently, while the risk of closing my practice would affect my livelihood, I am very aware that it would have a greater impact on my patients, who currently number 25-30 Australians per week. If these patients were to seek alternative bulk-billing psychologists in the vicinity and/or sessions outside normal business hours, they would face a considerable struggle. So, while closing down my practice would obviously impact myself, I am concerned that this would result in the 'Better Access' To Mental Health Services scheme, limiting access (ironically!) for many of my patients.

I believe that many proponents of a one tier rebate system for psychologists state the Medicare Better Access scheme evaluation as evidence of no difference in service provision and effectiveness between general and clinical psychologists. The National Committee of clinical psychologists have recently advised that *"there are many significant research methodological issues that diminish the credibility of the study. The study did not meet fundamental standards of research design (it did not identify the nature, diagnosis or complexity of the clients seen by psychologists by type of psychologist; it did not identify the nature or type of psychological intervention actually provided; it did not factor in or out medication use by the client; it did not factor in or out therapy adherence indicators; it did not have a valid criterion measure actually related to a range of diagnoses or complexity in order to assess pre and post intervention condition of clients; it did not undertake follow-up assessment of clients, which is often the point at which the relative strength of any competent treatment becomes manifest; it did not determine relapse rates by type of psychologist; it was a self-selected sample of psychologists who self-selected their clients and clinically administered the research questions in session; it was not subjected to peer review); and what is needed is a well-designed prospective study aimed clearly at answering specific questions in accordance with principles of psychological research."* Clearly, this is flawed research being used for purposes other than for which it was designed, and therefore should not be used as 'evidence' to make significant changes to the structure of mental health / psychology provision in Australia.

Finally, I would like to state that I would have liked to have had more time to add to this submission and argue my points in a more substantiated manner. However, as a very time poor professional, I have been unable to fulfil that need as well as I would have liked, in order to help guarantee the continued provision of relevant cost-effective mental health services to Australians in need of specialist help.

I also regret that I have been scared into not divulging my identity with this submission, as much as I would have been willing to do so, due to the activities of a new psychology organisation in Australia going by the name of *Australian Association of Psychologists inc* (AAPi). This organisation that appears to operate anonymously, and which sends many thousands of spam-emails to psychologists nationwide, is threatening to name (bad-mouth?) all psychologists who write to the current Senate Inquiry in support of the two tier psychology rebate system as I have.
Thank you for considering this submission.

31st July 2011.