# SUBMISSION TO THE COMMONWEALTH FUNDING AND ADMINISTRATION OF MENTAL HEALTH SERVICES COMMITTEE INQUIRY

Dear Sir/Madam,

Please accept my submission on selected terms of reference for the Commonwealth Funding and Administration of Mental Health Services Inquiry.

***a) The changes to the Better Access Initiative, including:***
***ii) The rationalization of allied health treatment sessions.***
Clients make use of the current allowance of twelve to eighteen sessions in various ways, depending on the severity and complexity of their mental health issues. For straightforward issues twelve sessions allows for two sessions to assess the problem followed by eight to ten sessions of therapy and is adequate. However, many of the clients I see present with complex and long-standing mental health difficulties, compounded by ongoing life stressors. Therapeutic sessions are at times used to respond to immediate crises, or to offer psychological first aid following additional traumatic experiences, meaning that more than twelve sessions are needed. Adequate care of these clients will be impossible within ten sessions. Moreover, for those clients who are parents, the risks associated with parental psychopathology are severe and problems frequently become intergenerational. Without access to adequate sessions (and even eighteen is at times inadequate) there will be significant worsening of mental health in the Australian community.

***e) Mental health workforce issues, including:***
***i) the two-tiered Medicare rebate system for psychologist***
As a Clinical Psychologist, I have a four year Bachelor of Psychology, a Masters Degree in Clinical Psychology and a Ph.D. This equates to nine years of tertiary education, in addition to two years supervised clinical practice. The postgraduate degrees were entirely focused on mental health and illness across the lifespan. I work with children, adolescents and adults, and specialize in working with people experiencing anxiety, including Post-traumatic Stress Disorder and Obsessive Compulsive Disorder. I also work with children and adults suffering Depression (including Post-natal Depression), Personality Disorders, Autism Spectrum Disorders, parenting difficulties and behaviour difficulties.

The two-tiered Medicare rebate system has unfortunately created significant division within the profession. It is my opinion that all psychologists with specialist recognition (i.e., those with at minimum a Masters degree and eligibility for membership of one of the APS Colleges) provide valuable service to their clients and have expertise in the domain of their specialty. They deserve to be appropriately remunerated for the work they do, but the question is, who is responsible for funding this? Is it a health funding issue, or perhaps more appropriately an educational funding issue, or justice funding issue, or corporate funding issue depending on the specialty? Many of these psychologists have worked hard to have their voices heard on this issue; it would seem the message that has been heard is that Clinical Psychologists should have their rebate lowered, rather than that other areas of specialty should also be eligible for higher rates of funding. Clinical Psychologists are highly

trained in the assessment, diagnosis, and treatment of mental illness across the lifespan, and have strong skills in conducting and understanding research into moderate to severe psychopathology. We are trained to work with clients experiencing chronic and severe mental illness, and this is directly relevant to Medicare funding, which is, after all, dedicated to *health* issues.

I understand that the Senate Committee has been asked to find budgetary cuts. Perhaps one alternative to reducing the specialist psychology rebate is to reduce the demand on GPs to review progress after six sessions. Clinical Psychologists have expertise in the assessment of mental health problems (including therapeutic progress) and perhaps this can be put to more efficient use in the management of clients. In my experience, the review conducted by the GP after six sessions is at times extremely brief and in essence bureaucratic rather than functional. While there are GPs who request their patient attend regular appointments to monitor psychological progress, there are certainly others who comply because Medicare requires it, rather than because they believe there is value in the review. An allowance could be made for a review with the GP if warranted at a therapeutically useful time rather than at an arbitrary interval. To cut this review (Item 2712) would significantly reduce the required budget and streamline continuity of care.

While included in the terms of reference as a workplace issue, the reduction in the specialist Medicare rebate will significantly impact on community access for the most disadvantaged and/or severely impaired groups. I currently bulk-bill approximately 40% of my clients, based on individual assessment of need. While some of these clients might meet criteria for already stretched community services, others do not. These types of clients are supported by the current higher-level rebate that allows me to bulk-bill while still meeting practice costs and earning an income. I would be unable to bulk-bill to the extent that I currently do if the rebate were reduced, and I suspect other Clinical Psychologists would also need to review the percentage of clients who are bulk-billed.

In summary, it is in the best interests of *clients* that the higher rebate be maintained and Clinical Psychologists are well-trained and worth the health care investment. Reducing the rebate will hurt the community, and while it may create professional equity it won't actually benefit other psychologists. It probably also means that there will not be another opportunity to increase rebates for everyone, whereas maintaining the current rebate sets a precedent for other health focused psychologists to continue to lobby for adequate recognition and improve overall mental health care.

***ii) Workforce qualifications and training of psychologists***

There exists considerable variability in psychologist training. As mentioned above, I have three tertiary degrees, plus two years of supervised practice, in addition to clinical experience. This is consistent with most other Clinical Psychologists, who have a minimum of eight years of training. If the level of training of psychologists eligible for the generalist rebate is considered, much greater variability is found. There are many generalist psychologists working with a masters degree and/or Ph.D and many years of experience who deserve equal recognition; however there are also psychologists working with a four year degree and two years of workplace training. In my experience (as a student and a supervisor) undergraduate degrees do not offer extensive grounding in psychological therapies. The psychotherapeutic skill four year trained psychologists hold is therefore

significantly dependent upon the quality of supervision they received in the workplace. In identifying areas of cost-cutting, perhaps the level of training needs to be taken into account, rather than reducing specialist rebates.

Thank you for considering my thoughts on these three issues. I hope the Committee is able to find the required budgetary cuts while maintaining and perhaps even extending the standard of Mental Health Care that has been developed since 2006.

Yours Sincerely,

Dr Kelly Murray
4 August 2011