

## **Commonwealth Funding and Administration of Mental Health Services**

### **Senate Community Affairs Reference Committee inquiry into Commonwealth Funding and Administration of Mental Health Services.**

#### **Submission from clinical psychologist**

To the Senators

I wish to address the following terms of reference before this committee regarding the proposed changes to:

**(b)** the Better Access Initiative:

(ii) the rationalization of allied health treatment sessions

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

**(e)** Mental Health workforce issues:

(i) the two-tiered Medicare rebate system for psychologists

Please note that the views expressed are my own personal views and are not written on behalf of the health service for which I work i.e. Alfred Health. I write as a clinical psychologist of over 20 years experience working in the public health sector, the last 10 years as a Manager of Psychology Services and four years working as a private practitioner.

#### **(b) (ii)(iv)**

While 10 sessions may be adequate for individuals with “mild “mental health issues for those clients with moderate or severe difficulties this proposed change will mean that they will have access to psychology services less than monthly over a calendar year. In my experience psychology treatment services are most effective when provided on a weekly or at a minimum fortnightly basis at least until the client is able to manage symptoms and their distress more effectively. Given that clients will require at a minimum one and more usually two assessment sessions before treatment can begin, this only leaves eight sessions for intervention.

Many clients with moderate to severe difficulties have chronic problems which have a significant impact on the individual’s ability to function in a number of areas including work, study, family, relationships as well as physical health. These clients should not be denied the right to effective treatment by the reduction in sessions.

In my own small private practice I have worked and continue to work with clients with chronic psychotic and moderate to severe mood disorders, many of whom I bulk-bill. These clients are also engaged with private psychiatrists largely for medication management.

These clients will be disadvantaged by the reduction in sessions; to limit their access to only 10 sessions per calendar year is to limit their access to treatment which can enable them to function more effectively despite on-going difficulties. The reduction in sessions will mean that there is limited flexibility for increasing the frequency of contact during periods of increased distress/ instability because to do so may mean that there will be many months in the year where they will have no access to services – these patients are not in a position to pay for sessions outright. The reduction in session is also likely to mean an increased burden on general practitioners to provide mental health follow-up.

The argument has been made that these clients would be better served by:

- public mental health services
- private psychiatrists
- the Access to Psychological Services (ATAPS) program

However in my experience these clients would not be considered severe enough for public mental health services which only provide services to clients with the most severe mental health problems.

Many clients with moderate to severe difficulties benefit from contact both from private psychiatrists and psychologists with the psychiatrists providing medication management and the psychologist providing psychological interventions as is the case for a number of my private clients. While the ATAPS program may be an option for clients with moderate to severe difficulties it does limit their right to choose the psychologist with whom they want to work.

In addition, in my private practice I have worked with a number of clients under the age of 25 yrs – a group which is recognized to be vulnerable to mental health issues – although they may appear to have “mild” problems they are grappling with issues of identity and sexuality which if not adequately addressed makes them very vulnerable to developing long term problems as well as putting them at risk of sexually transmitted diseases and significant substance abuse. The younger age group is often difficult to engage, engagement takes time, once again 10 sessions is a very small number of sessions in which to engage young people in treatment and to address issues of identity and sexuality which often underpin their presenting problem and is frequently complicated by substance abuse.

A consequence of the proposed changes is that clients who have received ten sessions this calendar year prior to November 1<sup>st</sup> will not be able to attend further sessions until January 1<sup>st</sup> 2012. This is a two month gap without access to psychological services at a particularly vulnerable time when many other clinicians- GP’s, private psychiatrists are on leave or difficult to access.

In my role as Manager of Psychology services at The Alfred I am well aware of the pressure on the public mental health services and the need for these services to identify appropriate discharge options for clients. The current arrangements ( 12 sessions or 18 exceptional circumstances) has allowed clients with serious mental illnesses such as moderate to severe mood disorders and psychotic disorders to be discharged to private psychologists and/or private psychiatrists as well as their GP. With the reduction in sessions the option of

discharge to a private psychologist will become less viable placing more pressure on the already overstretched public mental health system

**(e)(i)** The two-tiered Medicare Rebate system for psychologists.

Other than Psychiatry, Clinical Psychology is the only other mental health profession whose complete post graduate training is in the area of mental health. Consequently, due to their theoretical, conceptual, empirical and applied competencies, clinical psychologists are specialists in the provision of psychological therapies.

The current two tier system recognizes the additional years of post graduate training undergone by clinical psychologists over their generalist psychology and allied health colleagues. It has been a principle within medicine and allied health disciplines to recognize specialist training through increased remuneration as currently exists within the two tier system.

The removal of the two tier system is likely to result in reduced numbers of clinical psychologists choosing to work privately and who will be willing to bulk bill clients. Thus it is likely to be harder for public mental health services to find private clinical psychologists who are willing to accept their clients for follow-up as they are often clients with more significant difficulties – which will be difficult to address in the reduced number of sessions - and who often cannot afford to pay.

It is also likely to lead to a reduction in the number of psychologists choosing to do post-graduate clinical training (Masters or Doctorate) resulting in reduced clinical expertise in the psychology workforce. This reduction in clinical expertise is relevant for the public sector as well as the private. Post graduate clinical training is a basic requirement for public mental health service positions in the service in which I work and to the best of my knowledge in most other mental health services precisely because of the required expertise in the assessment and psychological treatment of mental illness. A reduction in psychologists going on to do this further post-graduate training would have a significant impact on the available clinical psychology workforce available to work in public mental health.

Clinical Psychologist.