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

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Submission by
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Thank you for the opportunity to make this submission.

I am a Clinical Psychologist practicing in regional northern NSW with over 12 years clinical experience in the field of mental health and in the provision of psychotherapy and psychological interventions.

I would like to express my deep concern for the proposed changes to the Medicare Better Access Scheme which would see the number of Medicare rebated clinical psychology sessions reduce from 12-18 down to 6-10.

I would also like to comment to retain the higher tier of Medicare rebates available to specialist Clinical Psychologists.

I have also offered some recommendations on the provision and administration of Mental Health services based on my clinical expertise, experience and training as a specialist Clinical Psychologist.

As a Clinical Psychologist in independent private practice in regional northern NSW, the majority of cases I see are complex in nature, with patients often presenting with co-morbid psychological conditions. I would rate the majority of my patients in the moderate to severe range of psychological functioning. This is typical for the referrals I receive . At present, the maximum 18 sessions accessible through rebates to patients, I believe, is inadequate. To further reduce the number of sessions accessible to individuals down to 6-10 presents a multitude of issues and compromises the availability and effectiveness of psychological treatment.
I believe there is also an ethical issue in taking on a patient for whom a longer term treatment process is required. With specific expertise in eating disorders and characterological issues which can often present as the most common of anxiety and depression referrals and may only reveal themselves some time into therapy, I would hesitate to feel able to provide an adequate psychological service knowing 6-10 session would only scrape the surface to establish the stability, therapeutic rapport, and clinical foundation from which to start to therapeutically intervene. I fear these patients' treatment options would be severely limited should the proposed changes be implemented.
For those who respond to psychological interventions within 10 sessions (ie those whom are classified 'mild- moderate'), the proposed changes may not present a disadvantage. However, it is those who require the greater level of support, relationship, input and expertise, for whom I fear will suffer under the proposed changes.
I fear for the 19 year old young woman struggling with anorexia nervosa, a complex mental health condition, who after half a year of weekly sessions is starting to consider making changes to her eating patterns, who will be left unsupported with no option but to go it alone or seek an alternative service provider to continue the recovery process. I fear for the 40 year old woman with chronic depression and debilitating anxiety who, with a history of

trauma and parental neglect early in life, has finally sought assistance and is developing the capacity to trust, only to have her access to ongoing clinical psychology input and treatment, cut short. I fear for the 25 year old young man struggling with posttraumatic stress following an horrific car accident in which his friend was killed, now also struggling with guilt, self loathing and at significant risk of suicide.
These are just a few of the many clinical presentations I see that rely on the continuity of expert clinical psychology input. Treatment of these patients under the 10 session scheme may have unintended negative consequences as session limits will likely require that treatment be interrupted or ceased prematurely. Such treatment interference may result in symptom exacerbation or relapse; treatment aversion; or may reinforce long-standing patterns of isolation, rejection/abandonment and hopelessness, particularly for individuals with trauma or personality disorder presentations. For these reasons I have serious concerns regarding the ethics of providing treatment to such patients referred to me under the Better Access Scheme, if the new session limits are to be implemented
I believe the proposed changes are a disservice to those individuals for whom we are seeking to assist. I am dismayed that these changes are suggested to be in the best interest of those with chronic and complex mental health conditions. In fact, it is those who require clinical psychology input the most that are disadvantaged under these proposed changes. I urge the committee to retain *and extend* the number of rebated clinical psychology sessions through Medicare's Better Access Scheme.

I would like to recommend that the number of sessions available to Clinical Psychologists be increased to at least 20 sessions a year, ideally unlimited/at the Clinical Psychologists' discretion/judgment in order to offer the necessary clinical psychological support required to provide containment, stability and intervention particularly to those with entrenched and complex psychological disorders.

Best practice in psychological intervention would suggest conjoint sessions with partners, parents or family be indicated when working systemically with individuals with mental health issues. In my work with adolescents and adults with chronic eating disorders I often meet with family members and partners as part of treatment. In addition, the flexibility to provide extended sessions (50+ mins), particularly for assessments and therapeutic interventions, would enhance service delivery and treatment outcomes.
Furthermore, with the emphasis on collaborative treatment leading to better outcomes in patient care, case conferencing, consultation and liaison with other treatment providers should be able to be billed.
Current Medicare arrangements do not provide for these opportunities to occur within the rebate system.

I would like to recommend the addition of Medicare item numbers for Clinical Psychologists to provide longer consultations and consultations with a family member or partner. Additionally, I would like to recommend the addition of Medicare item numbers to allow for consultation, liaison and case conferencing with other treatment providers involved in patient care.

I would like to comment on the referral process currently in place for access to the Better Access Medicare rebates. I believe the process which requires the preparation of a Mental Health Care Plan (MHCP) and referral from a GP, is cumbersome and costly. Given Clinical Psychologists are highly qualified professionals with specific expertise in assessment, diagnosis, formulation, treatment planning, psychotherapy and evaluation of psychological interventions, I would like to see the referral process simplified. GPs should be able to refer, as they do to other specialists, with a referral letter being sufficient and adequate. Clinical Psychologists as standard practice, perform a mental health assessment which informs treatment planning. Standard practice also involves liaison and collaboration with the

referring GP which will not be lost should their preparation of the MHCP be made optional rather than necessary.

I would like to recommend that there be a change in the referral process by GPs to specialist Clinical Psychologists. A referral letter from the GP to the Clinical Psychologist should suffice, with no requirement for the preparation of a MHCP.

I received my Clinical Psychology training, and was awarded my specialist title as a Clinical Psychologist in WA. The training requires completion of an accredited postgraduate qualification, that is at least a Masters degree in Clinical Psychology, followed by a two year period of supervised practice as a Registrar, before full recognition as a Clinical Psychologist is granted. The sequence of eight years education and training in order to practice as a Clinical Psychologist, is a demanding and rigorous program and provides assurance of attainment of competency in the many clinical and professional skills required to practice effectively.

I have been dismayed and disheartened to hear of the possibility of a single Medicare rebate for all psychologists, which I believe equates to a devaluing of the skills, competence and expertise specific to specialist Clinical Psychologists who have attained accredited postgraduate training in clinical psychology. Retention of a higher tier of rebate recognizes the investment and skill attainment of Clinical Psychologists.

Coming from a state where the Clinical Psychology profession has had a clear and defined role in the workforce (both private and public), and where the public health system had a work value in place which enabled the attraction and retention of highly skilled, qualified specialist clinical psychologists, I would suggest a nationwide salary scale, equivalent to that in WA to specialist clinical psychologists, within the public health system.

I would like to recommend that the higher tier of Medicare rebate remain for Clinical Psychologists with accredited postgraduate training in Clinical Psychology.

In addition I would also like to recommend that the committee consider increasing the rebates available to specialist Clinical Psychologists, in order to encourage, retain and attract the calibre of psychologist qualified to provide comprehensive services, particularly in remote, rural and regional locations, both in the private and public sector.

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