Submission to Senate Inquiry:
Commonwealth Funding and Administration of Mental Health Services

To Whom it May Concern,

This document is tendered pursuant to notice of motion referred to the Community Affairs References Committee for inquiry and report by 16 August 2011 with respect to the Government's funding and administration of mental health services in Australia.

As a Generalist Psychologist in Private Practice based predominately on referrals through the Better Access program I feel, for the first time, compelled to make a submission to such an inquiry reflecting my concerns pertaining to the following matters:

(b) changes to the Better Access Initiative, including:

(i) the rationalisation of general practitioner (GP) mental health services

GP's are threatening to stop writing Mental Health Care Plans. The original spend for the Better Access Program was almost double it initial appropriation, clearly demonstrating the demand and need for mental health services.

Is it the objective of the current proposed measures to kill all this? How is it not clear that rationalising GP mental health services will substantially decrease referrals and thus the supply of mental health care to our society?

Help seeking behaviour in mental health is rare, so a government program that simply adds another barrier to entry makes no sense. The overwhelming benefit of the Better Access Program, among others, was that it provided accessible, affordable psychological care to middle Australia – our largest demographic as a developed society.

The primary care model is cemented into the Australian health care system, so without GP referrals a bottleneck will form and reduce an individuals ability to access affordable psychological care. Leaving hundreds of thousand of middle and low income Australians flooding an already overworked and underfunded public system.

PROPOSED SOLUTION: reduce what GPs are required to do for their reduced time and rebate. For instance, there is no need for the GP to do an in-depth mental health assessment as any professional psychologists worth their salt would do their own upon client's presentation. A brief determination on whether a referral is required via a K10 or DASS checklist and a detailed referral letter to the psychologist of their choice would suffice for GPs to be paid a Medicare Rebate.

(ii) the rationalisation of allied health treatment sessions

Reducing the number of rebated sessions available from 12 to 10 flies in the face all international research regarding the level of care required for a client to make a sustainable improvement.

This is simply inadequate for most mental health issues facing individuals in our society today, even mild presentations. Most diagnoses demand more than 6 sessions for effective treatment – and if taxpayers are to receive value for their Medicare dollars by reducing relapses.

As the latest Australian Psychological Society survey indicated – "In the first three years of the Better Access initiative (2007–2009) 2,016,495 unique individuals received services from psychologists under Better Access and 262,144 (13%) of these people received more than 10 sessions of psychological treatment".

Best evidence based practice within the psychological research is clear that 12 sessions of Cognitive Behaviour Therapy (CBT) are required for effective treatment of disorders such as Major Depressive Disorder and Generalised Anxiety Disorder (those most prevalent in our communities). In fact, many of the more severe and complex diagnoses require a great deal more in order to ensure effective treatment without relapse or risk to the client.

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PROPOSED SOLUTION: by reducing the need for GPs to complete a mental health assessment, reallocate this funding for 1 or 2 *assessment* sessions with a psychologist. This would then leave another 6 to 10 *treatment* sessions with that psychologist (bringing it back up to 12 sessions).

(c) the impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program

I believe the ATAPS Program is beneficial for lower socio-economic clientele unable to afford a gap fee and, as a result, serves as a critical support for an already inundated public mental health system.

ATAPS is also a key complimentary program for the Better Access Program. ATAPS is essentially a bulk-billed offering and Better Access is a service requiring a small gap fee – hence delivering psychological care for two different socio-economic groups. Having both programs available to the community facilitates access to support for both individuals able to pay a small fee for services and those unable to pay at all.

I believe both funding arrangements are required as a private practice would be unviable on ATAPS referrals alone.

(e) mental health workforce issues, including:

(i) the two-tiered Medicare rebate system for psychologists,
(ii) workforce qualifications and training of psychologists, and
(iii) workforce shortages;

A matter that should be of particular interest to the Committee is the fact that ***the vast majority of psychologists in Australia are 'Generalist'*** **registered**. By reducing 'Clinical' psychologist rebates to be equivalent to that of a 'Generalist' a substantial cost saving could be achieved, thus enable the wider distribution of funds and services.

I realise that the clinical psychologists in our profession are very vocal about this and are arguing for higher rebates. However, the fact remains that many generalist registered psychologists are extremely knowledgeable and effective clinicians with extensive experience in the field.

An Australian Psychological Society survey found ***clients are receiving effective psychological treatment under the Better Access initiative.*** That is, at the commencement of treatment, **83.6%** were rated as having a moderate to severe (40.5%) or severe presentation (43.1%). At the conclusion of treatment, **42.6%** were rated as having no residual symptoms (10.2%**)** or a mild presentation (32.4%), while only **2.5%** retained a severe presentation.

With this figure being made up of both clinical and generalist registered psychologists, how then can it be argued that generalist registered psychologists are not providing effective treatment. Again I state - *the vast majority of Psychologists in Australia are 'Generalist registered'*.

Most psychologists (generalists) do not enter private practice without first having worked in clinical settings for many years and undertaking extensive professional development and further education throughout this time. This provides years of practical client care experience at the coalface of mental health. In many cases, clinically registered psychologists have undertaken considerable study, but have scarily minimal client care experience before they start practicing.

Which is better to provide our mental heath care; a Master's student straight out of university, or a psychologist with 10 years clinical and 5 years private practice experience? If psychologists like myself are deemed experienced enough to supervise students (I am STAP accredited to supervise provisional psychologists) why are we not deemed good enough for the same Medicare rebate?

On the matter of workforce qualifications, I note the fact that very limited Masters placements are available at Australian universities.

How then are we supposed to upgrade our qualifications to that of clinical psychologists?

We simply followed an education path deemed suitable when we commenced our careers but is now deemed second rate. Being penalised via a reduced Medicare rebate simply due to a recent accreditation change predicated on bureaucracy not my clinical experience, leaves generalist psychologists and the profession as a whole at a significant disadvantage.

PROPOSED OUTCOME: Simply remove the higher rebate for clinical psychologists, thereby creating a substantial cost saving, thus enabling a wider distribution of funds and services. Or introduce a Grandfather clause, whereby practical experience is assessed alongside postgraduate qualifications with equality.

I appreciate the Committee's time and consideration of the views expressed in this submission.

Although I agree with the profession as a whole that the rationalisation of sessions should not occur, I do, however, feel that the two-tiered model is not needed. It is a system of elitism in our profession, not a system of equitable access for those in need.

Thank you for your time.

Kind Regards,

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