

Submission to the Senate Standing Committees on Community Affairs: Inquiry into the Government's funding and administration of mental health services in Australia.

Introduction

I am a psychologist who has been registered for 19 years, 17 of those in Private Practice. In my 19 years I have provided clinical psychology services – by its very definition, all psychologists following the Scientist-Practitioner model practice clinical psychology.

However, following the ill-fated Medicare 2-tier scheme, I can now only practice “focused psychological” interventions with Medicare clients. I can and do practice clinical psychological interventions with all other clients as I have done for 19 years (WorkCover, Legal, and Private). By its very nature the Australian Government through Medicare, The Psychology Board of Australia and the Australian Psychological Society have decided that this most disenfranchised group (mental health consumers) must obtain a lesser services from me.

In this submission I wish to restrict my comments in relation to treatment by psychologists only and to specific areas of the Terms of Reference: (b – ii & iv), (c), and (e):

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

(ii) the rationalisation of allied health treatment sessions

(iv) 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

I cannot understand the difficulties this Government has with providing mental health services to the most needy in our society. This was a major component of its charter in the National Health and Hospitals Reform Commission.

Dr Christine Bennett, Chair, National Health and Hospitals Reform Commission in a letter to The Hon Nicola Roxon MP dated 30/6/09 states:

“With the needs and interests of the Australian people at the centre of our thinking, our reform agenda urges action to:

- Tackle the major access and equity issues that affect people now;
- Redesign our health system to meet emerging challenges; and
- Create an agile, responsive and self-improving health system for future generations.

We present more than 100 recommendations to transform the Australian health system. Some will have an immediate impact; others will take time to implement; and still others are for further development.

In Chapter 3 of the National Health and Hospitals Reform Commission, it states that tackling major access and equity issues that affect health outcomes for people now is of major importance.

“Ensuring that everybody can get access to effective and high quality health services is one of our most important priorities. Equity, or ‘fairness’ to use everyday language, is at the heart of the Australian health system, and is, indeed, a very strong part of the Australian social psyche. Many of our submissions were driven by a passionate advocacy of, and commitment to, improving access and equity in the Australian health system:

Ensuring that children have an equal start to life is recognised as a feature of a just and fair society, and is necessary for tackling health inequities in adulthood.

As a society, we are judged on how we treat our disempowered populations and people with mental illness are still significantly disadvantaged.

Unfortunately it is the most marginalised in our community who suffer the most from the failings of the current health system.

We strongly welcome the recent commitment by all Australian governments in the new National Health care Agreement that:

The health care system will strive to eliminate differences in health status of those groups currently experiencing poor health outcomes relative to the wider community.

What we want to do is turn that aspirational principle into something real, measurable and achievable. To do this, we first start by putting forward our proposals for strengthening the universal basis of our health system. Next, we examine specific areas where the health care system is failing particular groups now, and present our recommendations to achieve better health outcomes for these people.

Finally, we canvass some changes that will build a real commitment to improving access and equity into our health system on an ongoing basis.”¹

A copy of the final report can be found at:

<http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nhhrc-report-toc>

If, as they have stated, most people currently do not use anywhere near 10 sessions, so this justifies cutting the number of sessions back to 10. They should be congratulating the psychological population of Australia as ethical and highly effective practitioners. They do not use the 18 sessions just because they are there and they obviously have excellent

¹ <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nhhrc-report-toc~nhhrc-report-ch3>

clinical skills (both generalist and clinical endorsed psychologists as their own research has shown) as they can be effective in under 10 sessions.

However, there is a group of mental health consumers who need 18+ sessions and this is the first time in Australia's Health history that they have been able to access the appropriate services. This reduction in psychology services with the belief that severe mental health issues can be treated in under 10 sessions, is in direct contrast to the number of consultations psychiatrist are allowed under Medicare for the same condition (52 per year).

As a country that prides ourselves on Health Reforms and developing Health Literacy among our consumers, we have now taken away their choices. By its proposed and current policies the current government have taken away the consumers choice on who to go to for treatment (psychologist or psychiatrist) and which psychologists to consult (generalist with a lesser fee or clinical with a higher fee) all with similar interventions and similar results but with different gaps for them to pay.

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

In the latter half of 2010 the Psychology Board of Australia (PsyBA) assumed responsibility as the registering body for all practising psychologists and for granting endorsement status for specific areas of advanced psychological practice.

This has created a fake system of expertise as evidence in the February 2011 publication, *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative*, (Department of Health and Ageing, <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-ba-eval-ques>

This found that there was no difference between clinical and generalist psychologists and the expertise is a paper one only rather than a "real world" one. In fact it was found that generalist psychologists had slightly better outcomes.

From my involvement in various professional organisations at Executive level, and my many years of experience in Private Practice I believe that the following is the reason for this:

- Most psychologists in long standing Private Practice are Generalist Psychologists
- Many psychologists who have clinical endorsement have only entered the Private Practice field since the Medicare Initiatives and are less experienced.

This contrived system of expertise is further evidence by the system that psychologist were granted clinical endorsement by the APS and the PsyBA. People with similar backgrounds had different decisions regarding their level of expertise and therefore endorsements. Other psychologists were granted three different types of endorsements even though their Peers would not have supported this. This smacks of "endorsements for the boys".

The APS and the PsyBA have not acknowledged the long standing principles of "**Recognition of prior learning**" which has been used throughout various professional groups and Tertiary Institutions.

- **Recognition of Prior Learning (RPL)** — A process for assessing and formally recognising a student's existing skills and knowledge. These skills may have been obtained through formal or

informal training, work experience, voluntary work or life experience. The skills and knowledge recognised may assist with entry or provide a student with credit towards their course.²

- **Recognition of prior learning:** (RPL) Process of assessment of knowledge, skills and previous experiences in regards to those required to meet a qualification.³
- **Recognition of prior learning** Assessment that makes use of indirect evidence of achievement and/or evidence from activities that are undertaken without first requiring additional learning; often called recognition or assessment of current competencies; the term 'recognition' is meant to imply that skills and knowledge will be recognised by some form of assessment against established criteria.⁴
- **Recognition of Prior Learning (RPL):** a process of identifying and assessing the value of an individual's prior experience and/or learning, against the requirements of a particular course. This determines the exemptions or advanced standing that may be granted.⁵
- **Recognition of Prior Learning (RPL):** Accreditation of Prior Certificated Learning Scheme allows credit gained from past qualifications to be taken into account, where appropriate. It is also possible to award credit for learning derived from experience, where no formal qualification has been gained.⁶
- **Recognition of Prior Learning (RPL):** RPL is the formal acknowledgement of a person's competencies; regardless of how, when or where the learning occurred (eg formal or information training and education, work and/or life experience). It is an integral component of the vocational education and training system in Australia and is also referred to by a number of other terms, such as recognition of current competencies. See also Skills Recognition and Mutual Recognition.⁷
- **Recognition of Prior Learning (RPL) - VU** recognises that students gain knowledge from work and/or life experience as well as study. RPL Recognition of Prior Learning or Recognition of Current Competency (RCC) is an assessment process that applies to individuals who may have prior study, or relevant experience, but who do not have access to credit transfer arrangements for their chosen course.⁸

This has deeply divided the psychology profession and it has resulted in inappropriate and unnecessarily costly differentiation in the provision of mental health services to the community and confusion amongst clinical referrers.

As part of a World Health Organisation, The Ottawa Charter for Health Promotion, WHO, Geneva, 1986 states that "Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential."⁹

The operative wording is **equal opportunities and resources to enable all people to achieve their fullest health potential.** This has not been done by the introduction of the 2-tier system.

² <http://www.gooduniguide.com.au/Footer/Glossary>

³ https://www.training.nsw.gov.au/about_us/glossary.html

⁴ <http://www.atto.org.nz/glossary>

⁵ <http://www.student.qut.edu.au/about/glossary/r-v>

⁶ <http://www.staff-support.co.uk/glossary.html#R>

⁷ http://toolboxes.flexiblelearning.net.au/demosites/series12/12_09/toolbox12_09/resources/training/glossary/q_t.htm

⁸ <http://www.vu.edu.au/current-students/new-to-vu/glossary>

⁹ <http://www.ldb.org/iuhpe/ottawa.htm>

(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**

I believe that this will have major implications for the mental health of Australians.

- The most experienced practitioners of long term standing can no longer afford to practice, leaving the youngest, less experienced psychologists to deal with the most entrenched clients.
- Psychologists practicing next door to each other, using similar interventions with similar results will attract different rates (often the same fee is charged but one group of voting consumers using their right to choose will obtain a lesser rebate).
- Many long standing psychologists in Private Practice (who often service the rural areas) have had to accept lesser incomes. The Generalist rates are similar to rates psychologists were receiving in the 1980's, while our expenses have continued to escalate.

How are we building **health literacy** which has been shown to substantially change the health of a nation when the Government does not allow consumers to make choices.

“Health literacy in the ALLS is defined as: the knowledge and skills required to understand and use information relating to health issues such as drugs and alcohol, disease prevention and treatment, safety and accident prevention, first aid, emergencies, and staying healthy.”
*Australian Bureau of Statistics*¹⁰

If the Government wished to severely reduce psychologist numbers than it has been very successful. All this while the World Health Organisation states that:

“Depression is the leading cause of disability as measured by YLDs and the 4th leading contributor to the global burden of disease (DALYs) in 2000. By the year 2020, depression is projected to reach 2nd place of the ranking of DALYs calculated for all ages, both sexes. Today, depression is already the 2nd cause of DALYs in the age category 15-44 years for both sexes combined.

Depression occurs in persons of all genders, ages, and backgrounds.

Facts

- *Depression is common, affecting about 121 million people worldwide.*
- *Depression is among the leading causes of disability worldwide.*
- *Depression can be reliably diagnosed and treated in primary care.*
- *Fewer than 25 % of those affected have access to effective treatments.*

¹⁰

<http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4233.0Main%20Features22006?opendocument&tabname=Summary&prodno=4233.0&issue=2006&num=&view=>

Depression can be reliably diagnosed in primary care. Antidepressant medications and brief, structured forms of psychotherapy are effective for 60-80 % of those affected and can be delivered in primary care. However, fewer than 25 % of those affected (in some countries fewer than 10 %) receive such treatments. Barriers to effective care include the lack of resources, lack of trained providers, and the social stigma associated with mental disorders including depression.”¹¹

Finally, in The National Health and Hospitals Reform Commission – Final Report June 2009, Terms of Reference, states that it needs to address the following challenge:

“3 a) reduce inefficiencies generated by cost-shifting, blame-shifting and buck-passing;”¹²

THIS HAS YET TO OCCUR WITH THIS GOVERNMENT.

Maybe the definition of cost-shifting, blame-shifting and buck-passing was not adequately explained to them.

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¹¹ http://www.who.int/mental_health/management/depression/definition/en/

¹² <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nhhrc-report-toc~nhhrc-report-appa>