

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

As a fully qualified Clinical Psychologist and Director of two Clinical Psychology Group Private Practices, I would like to provide the committee with my input emanating from my daily work with Clinical and Generally Registered Psychologists and the many clients we serve. I would like to address specific aspects of the Terms of Reference (ToR) and will do so by listing the specific ToR followed by my comment.

(iii) the impact of changes to the Medicare rebates and the two-tiered rebate structure for clinical assessment and preparation of a care plan by GPs,

I am fully supportive of the two-tiered rebate structure for Psychologists. I believe this is a very accurate reflection of the difference in tertiary qualifications between Clinical and General Psychologists, with Clinical Psychologists studying for 6 years (i.e. to Masters level) whereas General Psychologists only complete 4 years of university study (i.e. to Honours level). In addition to the 6 years of university study, Clinical Psychologists then also have to complete two years of formal and intensive Clinical Supervision before they are able to claim Clinical Rebates for their clients. Although General Psychologists will complete two years of Supervision (which is not necessarily supervised by Clinical Psychologists) following completion of their 4 years of study, this Supervision period is often undertaken at only one employer (e.g. Job Network agency, Centrelink, etc). As such, these Psychologists obtain only limited exposure and experience, whereas a Masters degree includes multiple and different placement settings allowing a diversity of exposure and experience.

Please take note that I by no means devalue the excellent role played by General Psychologists or the amazing work done by them. I know many General Psychologists who have a passion for the work they do, however, I can't emphasise enough the theoretical framework and basis for, amongst others, clinical case formulation, and practical skills provided by a Masters degree in the field of Clinical Psychology. I think a lot of Psychologists working in private practice realise this over time and hence many General Psychologists at my practices have over time decided to complete the Clinical Masters Degree as it is so well-suite to the field of private practice.

With specific reference to the 'preparation of a care plan by GP's', I think GP's experience of completing such plans must be considered. Comments made by GP's to me with regards to this have included primarily the pressure they feel in having to complete these whilst having to manage the time pressures within their surgery. Many also feel that the paperwork required is very cumbersome. One GP I deal with will rather send a patient to me for an assessment session (for which the client pays privately). Upon completion of my assessment I would forward the GP the outcome of such with recommendations for further treatment. The GP will then use such to determine if the client is eligible for a Mental Health Care Plan and will provide such referral if needed. This provides the GP with the assessment information and speeds up the process of completing the Mental Health Care Plan. Personally, I think that Clinical Psychologists are uniquely qualified and positioned to complete such assessments. In an ideal world, I would suggest that Clinical Psychologists be tasked with such assessment and completion of the Mental Health Care Plan for the GP's review as part of the formal referral process. GP's should still be the primary caretaker of the client, but they could benefit from additional support in completing Mental Health Care Plans with such assistance from Clinical Psychologists. Alternatively, the paperwork involved for GP's must be decreased significantly whilst still remunerating them adequately for the preparation of the Mental Health Care Plan.

(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 strongly disagree with the reduction in session numbers available to patients with mild to moderate mental health concerns. Psychological treatment of most disorders involves a process approach including: 1.) Diagnostic Assessment; 2.) Establishing rapport and building a relationship with the patient; 3.) Psycho-education on the nature of the concern and the treatment/process that is to follow; 4.) Active Treatment; 5.) Relapse-prevention Psycho-Education. This process cannot be achieved over 10

sessions! We need to respect the nature of mental health disorders as a treatment process which cannot be rushed.

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

According to the Government, the changes to Better Access aim to provide better targeting of Better Access services to patients with mild to moderate mental illness, while patients with more severe mental illness will be provided more appropriate treatment under other programs such as the Access to Allied Psychological Services (ATAPS) program. This is confirmed by the Medicare Australia website which states “ These patients are likely to have more complex needs and may be better suited for referral to more appropriate mental health services such as the Australian Government’s Access to Allied Psychological Services (ATAPS) Flexible Care Packages”.

However, anecdotal feedback received from my local division of general practice (soon to be Medicare Local) has indicated that they would “align the ATAPS programme with the Better Access Programme”. In the past this has meant that the session numbers available will be mirrored. If this happens, i.e. also a reduction in session numbers to 10, it will defeat the government objective in using ATAPS to assist the more severe presentations, as 10 sessions will not be effective in adequately assisting such patients. The alternative is of course to over-run our already over-burdened Mental Health Departments. The problem there is of course that unless the client is actively suicidal or having active mania or active psychosis they are unlikely to be taken on as a client within these departments due to staff shortages. This leaves a huge section of the population to struggle with moderate to severe mental health disorders. As such, I would strongly suggest that Better Access continue as is (i.e. up to 18 sessions per calendar year) and that this be mirrored within ATAPS (i.e. up to 18 sessions per calendar year).

I trust that my feedback will be given due consideration.

Yours sincerely,

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