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Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600
Australia

Re: Senate Committee Affairs
Reference Committee Inquiry Into Commonwealth
Funding and Administration of Mental Health Services

Terms of Reference Discussed in this Submission : **The Government's funding and administration of mental health services in Australia, with particular reference to:**

(a) the Government's 2011-12 Budget changes relating to mental health;
(b) changes to the Better Access Initiative, including:
- **(i) the rationalisation of general practitioner (GP) mental health services,**
- **(ii) the rationalisation of allied health treatment sessions,**
- **(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,** and
- **(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;**

(c) the impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program;
(d) services available for people with severe mental illness and the coordination of those services;
(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;

(f) the adequacy of mental health funding and services for disadvantaged groups, including:
- (i) culturally and linguistically diverse communities,
- (ii) Indigenous communities, and
- (iii) people with disabilities;

(g) the delivery of a national mental health commission; and
(h) the impact of online services for people with a mental illness, with particular regard to those living in rural and remote locations and other hard to reach groups; and
(j) any other related matter.

Dear Secretary,

In this submission I write in support of the following 5 issues associated with areas highlighted in bold in the above list of the **Terms of Reference** :

1. Retention of the two-tier system of generalist and clinical psychology;

2. Maintenance of the fee structure for Medical Practitioners assessing clients for Medicare Better Access to Mental Health (Better Access);

3. Retention of the availability of up to 12 to 18 sessions of treatment for clients diagnosed with Moderate to Severe Mental Health problems;

4. Reviewing the proposal to use ATAPS system for management of the more seriously, mentally disturbed clients under the Better Access System.

5. Issues between mentally ill clients requiring hospitalisation - and clients with mental health problems seen under the Better Access Program.

Issue 1: Retention of the two-tier system of generalist and clinical psychology

It will be obvious to the Senate Committee that a large number of submissions have presented information supporting the professional distinction between Generalist and Clinical Psychologists by virtue of the latter's higher, far more intensive and extensive training and experience in the assessment and treatment of Moderate to Severe Mental Health Problems – having spent their post graduate years entirely addressing those issues.

It is also obvious that a lot of noise has been generated by some generalist psychologists who argue:

a. that both groups are capable of dealing with cases with moderate to severe Mental Health disturbances, clients, and who…

b. mention of a study by Better Access purporting to demonstrate no difference between generalist and clinical psychologists in their effectiveness with mental health clients: cited as "....evidence which refutes all claims of superiority of 'clinical psychologists'."

Within **many** fields of science, including psychology, initial studies can at times come up with findings that appear to show a certain treatment or procedure as being more effective only, after more rigorous examination of the research methodology used and/or further testing by other, independent researchers, to not as effective as claimed - or worse, that the effects don't last as well as other established therapies. The research on which the claim of no difference between generalist and clinical psychologists was made has been soundly refuted on methodological grounds; ie, problems in the selection of clients, the types and severity of their disorders, types of intervention, who did or didn't have medications at the same time and what the follow

up of clients would have revealed. In certain studies comparing different therapies, substantial significant improvements have been shown to have taken place over time - from 6 months to two years after treatment while other therapies have been shown to not hold up over time. No consideration was given to the possibility of this - let alone the need to have designed a study that would have resulted in comparing the two groups fairly. A more detailed listing of these points is given by other psychologists in their submissions.

Over and above the basic psychology degrees fulfilled by most generalist psychologists in their training, clinical psychologists have undertaken several years of postgraduate university environments almost exclusively involving training to work with cases of moderate to severe mental health disturbances using therapeutic techniques scientifically verified as effective.

The claim that no difference exists between generalist and clinical psychologists doesn't stand up in face of the evidence of their effectiveness that postgraduate degrees in psychology in countries such as Canada, England and the USA have been created in order to provide the necessary high level of skills necessary to effectively tear those with Moderate to Severe Mental Health disturbances.

Issue 2: Maintenance of the fee structure for Medical Practitioners assessing clients for Medicare Better Access to Mental Health.

Referring Doctors are an integral part of the management of clients under Better Access. Reducing their fees is demeaning of general practitioners and of the total Better Access process. The time used by referring doctors is a necessary aspect of the process of deciding who is best fitted for handling which problems. Uncomplicated Mild to Low-Moderate problems can be effectively treated using general therapeutic skills while Moderate to Severe problems require the additional broad-based skills to do so with the more complex and difficult ones. Many doctors will most certainly cut their costs by **not** seeing and/or thoroughly assessing potential Better Access patients - further undermining the availability, along with the meaning of, what is meant by, "Better Access".

It may not be an unrealistic stretch to consider the likelihood of a flow-on effect: where further axing of Better Access may take place with the erroneous notion that less finances are required because, "fewer people are using the service".

Issue 3: Retention of the availability of up to 12 to 18 sessions of treatment for clients diagnosed with Moderate to Severe Mental Health problems.

It is well known that 12-18 sessions are necessary to adequately complete therapy with a majority of those with mental health problems - while those with severe problems tend to require more.

It is not always altogether clear at the outset just how many sessions a client may require to resolve their problems: no matter how well-trained the psychologist is. Clients will often only reveal the true extent of their underlying disturbance after they feel sufficiently safe, or when they cannot hold back because memories, emotions and bodily reactions cannot be contained any longer: revealing far more extensive problems that require an extension of their therapy.

Thankfully, this was **well** thought out by those who established Better Access when they put in place the "Exceptional Circumstances" provisions where psychologists were able to apply to the relevant medical practitioner for approval to provide up to a further 6 more sessions (the potential for a total of 18 sessions) in order to address those problems.

It is therefore extraordinary this factor is being denied or swept aside in order to supposedly "save costs" by imposing an arbitrary limit on the number of sessions cases can be seen. It just won't work. People will continue to break down in sessions and require more therapy - even though clients may come to the psychologist wiht mild-to - moderate problems. The figure of 10 sessions has been plucked from the statistic that most clients are seen within 10 sessions. The implications of the 10 session limitation will be serious.

Issue 4: Reviewing the proposal to use ATAPS system for management of the more seriously, mentally disturbed clients seen under the Medicare Better Access System.

ATAPS is already underfunded to provide services to socially and economically disadvantaged people . It is, however, a fact that many of such clients are **already** very adequately served under the Better Access! I and other clinical psychologist colleagues make a number of therapy time-slots available each week to see such clients under bulk-bill arrangements.

A serious issue has been created where ATAPS services are each given a set amount of money with which to provide mental health services to their clients: the problem being that general psychologists are used more often (because they cost less) for the provision of treatment such that the more serious cases are not being seen by Clinical Psychologists. Under the proposal to refer the more serious Mental Health problems to ATAPS, this issue will only become worse and Clinical Psychologists would need to be included in the system - perhaps undoing the cuts to sessions above 10 up to 18. Since the Government isn't likely to allow this to happen, cuts to clients with the most serious Mental Health problems will bear the costs of the Government's budget cuts.

A related problem is the fact that many referring doctors are not sufficiently skilled and experienced to assess the degree of mental disturbance in the clients they refer. When it comes, in the present system, to clients being referred to clinical psychologists with mild to moderate disturbance who are actually turn out to be far most seriously disturbed, this is usually not such a problem - but it certainly becomes a serious one when lessor-trained psychologists, in a flattened system where everyone is a generalist psychologist, many of those more disturbed clients will be the ones to suffer most under the Medicare cuts.

Issue 5: Confusion between mentally ill clients requiring hospitalisation - and those with mental health problems seen under Better Access.

It is often the case that clients with severe PTSD, Depression and Anxiety are reluctant to approach "psychiatric services" due to the stigma and inappropriateness of such services to their needs. Many do not want to see psychiatrists. A significant number are quite capable of being seen by clinical psychologists under Better Access - and many prefer to do so – even those in cases where their daily lives are significantly impaired and impoverished. These clients are not "the worried well": the idea that they are less important and worthy of consideration in the mental health sphere than those

with serious psychiatric disturbances “who have real problems” - a demeaning slur against psychologists and the general practitioners who refer all Better Access cases.

The implications of making cuts to Better Access along with ignoring the skills of clinical psychologists in handling the more severe cases will result in increased distress and disturbance, increased risks of self-harm and/or of harming others. Such clients will turn up more at GP practices and outpatient departments - and add to the costs of health services generally. There will most certainly be a need for a two tiered system to handle cases seen in ATAPS.

Philip Garner

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