

***Brian Johnston, Ph.D., MAPS***

***Clinical Psychologist***

***Submission to the Senate Community Affairs Committees in relation to the Inquiry concerning Commonwealth Funding and Administration of Mental Health Services.***

This submission comes from Brian Johnston. I was first registered as a psychologist in South Australia in 1973. I worked as a clinical psychologist in South Australia's public mental health services from 1988 to 2009 (21 years). I have also worked in a general hospital (Modbury Hospital), two community health centres, (one rural, one suburban) and for the Spastic Centres of SA (SCOSA). Since mid 2009, I have conducted a private practice in southern metropolitan Adelaide (address above.) Most of my work in the practice is under the Better Access Initiative, and all these clients are bulk-billed. The area the practice is located in, Seacombe Gardens, has considerable public housing. Referrals here come from the local area, but also more affluent nearby areas (eg Flagstaff Hill & Brighton), and a certain proportion come from across Adelaide generally and nearby rural areas because I have a good reputation arising from two decades work in public mental health and extensive experience in training Masters in Psychology students from Adelaide and Flinders Universities, and in training staff of mental health services, health services and NGOs. Over my twenty years in public mental health I supervised over 60 Masters clinical placements.

In this submission, I address some of the terms of reference for the inquiry.

(b) changes to the Better Access Initiative, with specific reference to the abolition of the exceptional circumstances provisions, which directly contradicts the Government's stated aims to help people with severe levels of disorder.

I am very concerned about the Commonwealth Government's proposal to reduce the number of appointments available to people under the Medicare supported Mental Health Treatment Plans.

I get people referred to me from all over Adelaide, quite often for Obsessive Compulsive Disorder (OCD). In particular, the Obsessive Compulsive Neurosis Support Group refers people to me. OCD is often a devastating disorder for sufferers and families, and the evidence based treatment is Exposure and Response Prevention, a therapy which takes between 12 & 20 appointments to institute. Under current arrangements, I see such people for 18 (or near that number) appointments under Medicare's exceptional circumstances provisions, when their disorder is severe, and they are participating actively in treatment, and they are showing signs of benefitting. It's a good scheme and a cost efficient one compared to ATAPS. It's very important to

recognise that clients with serious psychological problems (OCD, PTSD & chronic disorders) do not need and usually do not want to be assigned to multi disciplinary teams, which are very expensive to run, are more likely to encourage dependency and introduce bureaucratic obstacles to access (see (c) below).

Better Access is also a good scheme as a complement to Medicare rebates for seeing a psychiatrist. Psychiatrists are often hard to access, and although there are some who are well trained in cognitive behavioural therapies, most are not. Most psychiatrists provide medication and "supportive psychotherapy" which can go on for years, as a maintenance intervention, rather than a time limited treatment.

An audit of my work for 2010 showed that almost exactly 20% of my Better Access clients had between 12 & 18 appointments. A further 40% had 11 or 12 appointments. None of this work could have been completed under the new proposed arrangements.

Under the proposal to reduce the number of appointments from November onwards to 6, with a possibility of 4 more, I will have to say to most OCD sufferers, "**You cannot get an adequate treatment under the Medicare funded Better Access Initiative.**" It would be improper to take such clients on, pretending that they can be given appropriate treatment, (unless they can pay for about half the appointments themselves or via private health insurance.)

This distresses me a lot. While the arguments the Government is putting forward for the changes refer to giving priority to serious levels of psychological disorder, the impact of the abolishing of the exceptional circumstances provisions disadvantages those with severe levels of disorder. *In other words, the changes would achieve exactly the opposite of what was desired.*

OCD is just one example of severe problems, where clinical psychologists will more or less have to say to clients, "**Sorry, I'm funded to work with people with much less serious problems than you.**" This isn't why I work as a psychologist and, given my qualifications and decades of experience, seems topsy turvy! (A more impolite expression comes to mind.) Under the proposed arrangements, I'll still get plenty of work and be able to pay off my mortgage, **BUT many people will be offered half a treatment, or none.** That is my concern. I hope it's something Senators are concerned about also, and ask you to consider advocating for a reconsideration of the abolition of the exceptional circumstances.

(c) the impact and adequacy of services provided to people with mental illness through the ATAPS program.

People with chronic, medication-resistant psychosis do usually warrant ongoing support from multi-disciplinary teams. However, I do not understand why it is thought advisable to set up a new bureaucratic structure alongside public mental health services run by the states. Soon there will be local liaison nurses and liaison committees to coordinate between ATAPS and state mental health services! I suspect senators are only too familiar with how these scenarios can unfold, with more and more meetings and fewer people providing treatment services.

People with chronic depression, chronic anxiety, OCD and PTSD need treatment, best provided by one therapist, not a multidisciplinary team, an approach which encourages dependency and a career as a “mental health consumer.”

ATAPS is based on regions and thereby limits people’s choices in accessing services. For example, I have a 19 year old female client, who was denied access to psychological services organised by the division of general practice where she lives (in the northern suburbs of Adelaide), because she attends the GP she’s had all her life in the suburb where her family live (in the southern suburbs of Adelaide). This is not a good system, especially for young people, who sometimes move around.

Better Access is a better system because people are free to contact a therapist who may suit their needs even if not in their local area. For example, they may wish to approach someone who specialises in a particular problem, or who speaks a particular language, or who is knowledgeable of particular cultural or lifestyle issues.

(e) the two-tiered Medicare rebate system for psychologists.

I understand that some psychologists who are not accepted for the clinical psychology level of Medicare rebate resent the fact that recent Masters graduates can get the higher rebate after two years’ supervised clinical work. I have three close friends in this situation, whom I call on for peer consultation.

Nevertheless, I strongly endorse the present two-tiered arrangement. Around the English speaking world, universities are developing very strong cognitive behavioural therapy protocols for most psychological disorders. When I began my career, I thought that requiring 6 years of university training was laughable, because university courses in clinical psychology were not good enough to be considered essential. However, over the last twenty years, this has changed. While universities are not good environments for specific skill training, the present cohorts of clinical psychologists exiting Masters programs are highly selected people, who understand cognitive behavioural approaches and are well prepared to make a significant contribution to the nation.

Psychologists who do not qualify for the higher rebate can go through bridging procedures to qualify. I, myself, went through such procedures to join the clinical college of the APS as I do not have a Masters degree, so I’m in a good position to point out that this is available to ‘generalist’ psychologists.

If some of the present generation have been treated unfairly that is regrettable, but the higher rebate for clinical psychologists should be maintained on the grounds that, in the future, Australia should have access to highly qualified cognitive behavioural therapists.

I do recommend that consideration be given to making the requirement for years of supervised experience greater. For example the clinical psychology level of rebate might only become available after 5 years’ supervised experience. (My having supervised over 60 clinical placements gives me some perspective on this matter, I believe.)

(j) any other related matter.

I assume that the abolition of the exceptional circumstances provisions of the Better Access Initiative is a cost saving measure. However, as explained above, it runs contrary to the government's own goals. Furthermore, if more people are referred to psychiatrists instead of clinical psychologist, this will cost the government more, not less.

If money must be saved from the Better Access program itself, the following procedures present more rational ways of doing so:

- restricting clinical psychologist level rebates to practitioners with 5 years' supervised experience,
- further specifying the criteria for exceptional circumstances and then auditing their application with the threat of recouping rebates in the case of inappropriate application, or
- restricting exceptional circumstances to clinical psychologists.

If you wish to discuss this further, please contact me as indicated in the letterhead,

Yours sincerely,

Brian Johnston