Submission to Senate Community Affairs Reference Committee into Commonwealth Funding and Administration of Mental Health Services

Thank you for the opportunity to submit comments to the enquiry you are currently undertaking into the funding and administration of mental health services in Australia.

The impacts of mental ill-health are enormous for any nation in terms of human and emotional costs on sufferers, their families and their immediate network, on communities, on the economy and on society as a whole. Approximately 15% of Australians suffer from moderate-severe mental ill-health and many more need assistance with mental health issues at some times in their lives. The financial costs are high and ever-increasing. Clearly, every effort must be made to ensure that interventions are focussed where results can be most effective and that Government funding is utilised in the most efficient way possible while being able to still produce beneficial outcomes.

I am a clinical psychologist with 40 years experience working in mental health, including with children, adolescents and families, in the Public Service and more recently, also a private capacity. I see clients who are mostly disadvantaged, many from rural areas, and all of whom have quite serious and complex mental health issues and I personally know from outcomes with thousands of clients what a significant difference good therapeutic intervention can make. A wealth of research evidence also shows that the alarming trajectory of many young people into adult mental illness, criminality, drug & alcohol addiction, intergenerational violence and abuse, chronic unemployment and many other problems which are enormously costly to society can be turned around, especially when the intervention is given as early as possible.

While fully aware of the need to ensure all Government funding is used efficiently and effectively for the Australian people, I have some concerns about what I perceive to be potentially adverse consequences of some of the proposed changes outlined in the terms of reference of this inquiry.

I personally bulk bill (though I know of no other clinical psychologist who routinely does this) and I am retiring next year. Hence I am not seeking to protect my own personal financial situation, only to assist the enquiry with comments and observations on the basis of my extensive experience.

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

- In my experience, much better outcomes can be achieved under the previous scheme when there is provision for 6 + 6 sessions, (and maybe 6 more) than the proposed 6 + 4 sessions only. A considerable proportion of my patients have required the 12 sessions to make significant positive and, importantly, lasting changes in their levels of functioning.

- A considerable proportion of the people I see suffering from anxiety and depression, post-traumatic stress disorder and so on have backgrounds of abuse, trauma and poor or disorganised attachment histories. A great deal of positive work can be done with people with such backgrounds and good therapy makes a very significant difference (also their families and the next generation). However, such patients understandably have difficulties with trust, safety etc and hence the work takes longer to achieve worthwhile results than with people from stable backgrounds. Stopping too soon gives them another experience of an unsuccessful relationship and makes it less likely they will seek help in the future.

- Similarly with people who have personality disorders, (which are likely to result in a great deal of distress, suicide, drug and alcohol addiction, abusive parenting and so on). There are "tests" which the patient often needs to put the therapist through before trust and rapport can be established and work can proceed to positive outcomes.

- If sessions are reduced, the new skills are less likely to be consolidated and the sessions which end up having to be cut are precisely those ones which normally come at the end of therapy, focussing on relapse prevention for the future. This seems to be a false economy.

- If the additional sessions are undertaken without the Medicare rebate, obviously a greater degree of financial burden then falls onto the patients themselves. This will inevitably mean that large numbers of people miss out on services they need, which will then place greater costs on the community in other ways.

Possible Changes to the Two-tiered Medicare Rebate System for Psychologists

- Clinical Psychology is a specialist branch of psychology where practitioners undertake at an additional 2 year post-graduate degree over and above a normal 4 year psychology degree. The Clinical Masters degree focuses on the theoretical understanding, diagnosis and treatment of mental health disorders and also provides further training in research methods and critical evaluation. Clinical students have practical placements in clinical settings and do their own research leading to an original thesis in clinical work. Extensive supervision is required after graduation from University before clinical endorsement can be obtained and before one can call him or herself a Clinical Psychologist.

- Hence Clinical Psychologists are equipped with a number of specialised skills which are not required by other more general psychologists and allied professionals and stringent requirements for supervision and professional development are in place to ensure that skills are updated and standards are maintained at a high level. In mental health, the skills of Clinical Psychologists are closest to Psychiatrists, though without the ability to prescribe medication (in Australia, anyway) and they are very much cheaper to employ (and more readily available) than Psychiatrists.

- In the Public Service Department of Health in which I work, only applicants with fully recognised clinical psychology qualifications are eligible to apply for psychologist positions, as it is considered that the specialist training is a valuable resource for provision of quality services to those with moderate-severe mental health issues.

- Clinical psychology is a recognised specialist area in most of the developed world, including the United States of America and the United Kingdom.

- It has been considered a specialist area in Australia for a number of years. It would seem to be a retrograde step to now abolish this level of specialisation in Australia, which could result in a reduction in the quality of services overall for patients with a range of mental health problems and also a loss of professional credibility and respect on the world stage.

- Becoming qualified as a clinical psychologist not only provides the training required for the most effective clinical work with people with moderate-severe mental health problems (approx 15% of the population, at least of young people), it also necessitates considerable extra costs for the psychologist eg
    - forgoing of salary for an additional two years study for the higher degree
    - significant additional HECS debts for the second degree
    - additional cost to belong to the clinical college of the APS as well as the general association.
    - high costs for mandatory ongoing professional development and training which is necessary every year to update knowledge and keep the clinical title

- It is reasonable to expect that with all these extra initial and ongoing costs to keep up clinical qualifications, there is some financial reward or incentive to acquire the higher skills. It took many years for psychologists to achieve Medicare rebates which allow them to make a reasonable living providing services to clients who could not otherwise afford treatment. If the Medicare rebates were to be reduced to the level currently paid to psychologists who are not clinically qualified or other allied health professionals, there is likely to be an exodus of specialised people from providing the services and hence many patients will be denied the help they need.

- The other alternative is that clinicians unwilling to take a very significant drop in overall income for the same amount of work will charge patients much higher gaps and without doubt, this would preclude a large number of people from being able to access the assistance and treatment the Better Access scheme was designed to give them. For some time, I have heard of people unable to pay the current gaps and hence dropping out of therapy before it is completed and this will become a much more frequent occurrence if the rebate to the practitioner is decreased.

- Inadequately treated, patients are then likely to need further mental health services in some other form later or else their difficulties might get worse without them bothering to seek further help because of the costs of services. In either of these cases, this would lead to significant emotional and financial costs in society which might well have been avoided if skilled treatment is funded in a timely and effective fashion.

In short, lack of incentive for psychologists to expend the huge amounts of extra time, money and effort required to gain specialist clinical qualifications could only lead to:-

  - a “dumbing down” of the profession,
  - a reduction in professional respect and status for Australian psychology and mental health in the international community
  - denial of highly effective specialist services to a very vulnerable and needy section of society

Surely it must be considered a retrograde step for the Government to have established such a popular and well used scheme, with proven good outcomes and then to deny people the number of sessions or the benefit of the specialist skills currently provided?

At the same time, a specialist profession is being asked to work at a highly skilled level for the same pay as someone with more basic skills. I can only wonder how it might be received if it was proposed that money could be saved by abolishing the two-tiered medical system and specialist doctors should receive the same rebate for services as a GP.

Although I can understand the need for cost savings where possible, it seems to me that on both of the terms of reference I have commented on, these would be false savings and ultimately lead to far greater financial as well as personal and social costs to the community.

I hope I have been able to provide some clarification on the difference between specialist clinical and generalist psychological services and I trust my comments above will be considered by the committee before a final decision is made at least on these two terms of reference within the current Senate enquiry into the administration of the mental health system in Australia.

Thank you again for the opportunity to comment. Best wishes for your important and complex task.

Yours sincerely,
Jennifer

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