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

25th July 2011

Dear Committee Secretary,

Re: Commonwealth Funding and Administration of Mental Health Services.

Thank-you for accepting this submission/letter outlining my concerns regarding the changes announced in the Federal Budget earlier this year. I will not address all the matters considered by your enquiry, but only speak from my experience and perspective.

The issues considered by this Inquiry are my day to day work, in all its forms. Please don't allow Mental Health Services to be reduced, it has taken such a long time for these issues to have some prominence it would be cruel to withdraw services from highly vulnerable people and it wouldn't address the issues of concern such as workforce shortage.

I am a Clinical Psychologist working in Launceston, Tasmania and work in a number of roles that provide me with a unique perspective on the issues of Mental Health Service delivery in rural and remote Tasmania. I have a small private practice, I work two days a week with my local Division of General Practice, two days a week with the University of Tasmania's Department of Rural Health as a Mental Health Academic, and have recently taken on a day a week of work with the University of Tasmania's School of Psychology as a Student Placement Coordinator for Northern Tasmania. I am writing, not as a representative of these organisations, though my work for each of them has helped in forming the opinions expressed in this submission, but of my own volition due to the concerns that the changes highlighted will have on the clients that I see within these roles.

I provide services both through the Better Access Initiative (BAI) and through Access to Allied Psychological Services program (ATAPS), and also have a role in establishing, promoting and supporting clinical placements in regional, rural and remote settings.

I am extremely concerned about the effective halving of the Better Access Initiative session numbers, particularly given the relatively small number of clients accessing the full 18 (less than 13%). There appears to be an assumption that there are alternative services that will 'fill the gap' – an assumption that is simply incorrect in my local region, even though I know ATAPS funding has been increased. It was my understanding that the initial purpose of the Better Access program was to 'catch' the unmet need of those experiencing the high prevalence disorders; those very clients who were not being seen by state based mental health services. In my discussions with our local mental health services, they consistently report that their role is to service the top 3% complexity of clients and they come from a tertiary service provision model, rather than a primary or secondary

health model. The assumption that state based (and funded) services are, or ever have been, able to meet the demand is absurd – I understand lack of services was the rationale for developing the ATAPS and BAI program. This rationale still exists. I have personally noticed that state services have consistently withdrawn from service delivery and regularly use BAI & ATAPS to refer to when they are unable to manage demand or don't have the skills and knowledge required to provide the appropriate service. There is no doubt that locally, clients are being seen under BAI, ATAPS or the Mental Health Nurse Initiative, when they would be most appropriately seen by state Mental Health Services, however they decline/refuse service. This means that 97% of clients presenting with Mental Health Disorders are not being seen by state based Mental Health Service or are seen as inappropriate to receive a service from them. Given the recent announcement of Tasmanian state budget and the amount of funds that are being withdrawn from services, I can only see this situation worsening and ATAPS and BAI being the most available support.

In my local region, there are three private psychiatrists, all working on a part-time basis, with I understand the actual equivalency being less than 1.0 EFT. They are barely able to meet demand for psychiatric/medical review, yet alone provide up to the 50 sessions that are available for them under Medicare each year for psychotherapy. This concept and expectation continues the city-centric focus on accessibility and availability of services.

I welcome the additional funding to ATAPS, especially for those with more severe and/or persistent mental health disorders, however as a provider of ATAPS services currently, I see no difference in client presentations based on whether I happen to see them in my ATAPS or Better Access roles. I am also acutely aware that capacity within both these spheres is stretched – with lengthy waitlists for both programs and services (which in my case are identical). Further funding is not going to resolve the issues of workforce or service provider availability (a significant issue in regional, rural and remote geographical regions, such as the one I work in), however, reducing access to one component of these services will severely limit accessibility – a goal I understand that these changes are meant to alleviate, not compound. There are simply not enough, experienced or otherwise, mental health professionals to deal with the demand for services.

The significant mental health issues that my clients' present with is not distinguished via the program with which they receive services, or by their geographical location. ATAPS has certainly enabled greater access to those in more remote areas, and I applaud and compliment the Government on continuing and extending this service. Without ATAPS funding there would not be the level of service delivery in rural communities that is currently available – ATAPS enables, in my region, service provision in Scottsdale, Campbell Town, George Town, Deloraine, Westbury, Beaconsfield, St Mary's, St Helen's and on Flinders Island, where private mental health services and often, public mental health services, are scant or not available. I also take every opportunity to take post graduate students with me, when I provide services in these regions and advocate strongly for, and extensively support placements that mean students are out of the regional centres. ATAPS enables me, and my colleagues to do this. It is how I personally can, and do, manage the significant workforce issues. When these services are oversubscribed and the waitlist closed, which is a frequent occurrence, I, like my private colleagues fill this gap through BAI, by seeing them with no out of pocket expense. I feel a professional and personal responsibility, to work with disadvantaged clients and provide access to a range of services, and to share that knowledge and experience with the next generation of psychologists.

Under ATAPS I have provided, and continue to provide services through Video and Phone conferencing. I am the only one of my colleagues in this role to have provided this service, despite all of us receiving the training. There is a significant reluctance to engage with the technology from a clinician perspective, let alone engage with a client in its use. The most successful interventions that I have undertaken with the aid of this technology have also involved the capacity for face-to-face intervention as an adjunct. This has been consistent in both my clinical and supervision experience. Whilst I think online treatments will have a certain role, they won't be able to address the social isolation and interpersonal issues that often accompany mental illness, and by their very nature, may increase these concerns. As for their capacity to be accessed by rural and remote communities, this would suggest that internet services are consistently available at low cost and at speeds that will enable these programs to run.

Like many of my colleagues, I bulk-bill those with low-income or on Government payments. I cannot see how these clients will be accommodated at the conclusion of 10 sessions, or that there is a reasonable, or equivalent, alternative service for them to be able to access. These changes leave psychologically vulnerable people without a support structure.

The issue of the two-tiered Medicare Rebate system for psychologists is extremely vexed and has been very divisive within my profession. I have, over the last few years spent over $10,000 to gain Clinical Endorsement through the Australian Psychology Board, and my clients benefit from the increased rebate available to them. For those who I don't bulk bill, the increased rebate leaves them $10 out of pocket, rather than the $25 + they were out of pocket prior to my clinical endorsement. I would identify that the clients I see are more complex than those of my colleagues, especially within the ATAPS program. I deliberately chose, and continue to choose, to work within ATAPS to enable disadvantaged and vulnerable clients, who are not based in a regional centre, to see some-one with expertise in the diagnosis and treatment of mental health disorders. Do I do this better than my Counselling, Health or Forensic colleagues simply because I happen to have Clinical endorsement? Are my interventions more evidence based? Is my area of speciality better than another? I don't think so. Expertise should be recognised for what it is, expertise in a specific area. Extension of the two-tiered system to recognise the other areas of expertise should be considered rather than the possibility of withdrawing from one. Whilst it is easy to get drawn into the professional infighting that is occurring within my own profession, my focus is on treating and supporting clients. The impact of all the changes outlined in the budget will effect clients, and not in a positive way.

In regards to training and supporting psychology or other allied mental health professionals, there is little more that I can personally do. I have a strong commitment to students, and new graduates, which my variety of work roles demonstrates. I could do any of these positions on a full time basis, however, to focus on one, would mean some-one would miss out. I continue in my clinical roles to enable clients who, by virtue of workforce shortages would not be able to access experienced clinicians. It would certainly be more financially lucrative for me to work full time in private practice in a regional or city centre, however clients, students and, I believe the local communities would suffer. The very fact that I hold such a number of jobs indicates the significant workforce shortage in my state.

To gain my own professional support, I need to go interstate, for both professional development activities (with each costing up to $1,000, by the time course fees, flights, accommodation, etc. are factored in) and supervision, which I am thankful my supervisor is willing to do over the phone. It is not easy to be a senior psychologist in a rural area. The demands are greater (clinically and ethically) and the access to supports is smaller. I do all I can to support my colleagues in maintaining their local practice as I strongly believe this helps people to stay when the work becomes difficult.

Should you require any further information, I would be happy to meet with you to discuss my concerns further.

Sincerely

Samantha Splatt
Clinical Psychologist