Committee Secretary
Senate Standing Committees on Community Affairs
Parliament House
Canberra ACT 2600

RE: Commonwealth Funding and Administration of Mental Health Services

I wish to make constructive comments on matters under consideration by the Senate Enquiry.

My background: I commenced work as a psychologist in the public sector in Queensland in 1970. I have been continuously employed in various clinical fields of psychology since then in Papua New Guinea, South Australia and the Northern Territory, finishing full-time employment in Queensland where I worked for Queensland Health for 25 years in the fields of alcohol & other drugs as well as child/youth mental health. Prior to my retirement I was a manager of clinical services for the Sunshine Coast Division of General Practice. I have a Masters degree in clinical psychology but I have not sought the title of clinical psychologist since it did not hold the importance to me at this stage of my career that it obviously does to many of my colleagues.

I have been awarded the rank of Fellow within the Australian Psychological Society and I have been an active participant in the provision of interdisciplinary education and networking throughout my professional career. I am very familiar with the operation of public sector services as well as those mental health services that operate under the ATAPS program and the Better Access initiative. Currently I provide consulting services on a part-time basis in my community.

In relation to the Committee's terms of reference, my comments are as follows

(b) Changes to the Better Access Initiative, including:
(i) the rationalization of general practitioner (GP) mental health services,

General medical practitioners clearly play a vital role in the detection and treatment of a wide-ranging of mental health problems and mental illness. We have an obligation to support and assist GPs in this very difficult endeavor.

I am certain that any objective audit of GP Better Access mental health care plans would show that the care plans in the majority of cases are of limited value to allied health service providers and certainly have not warranted the remuneration paid for these plans. Many GPs are quite happy to make a sensible and sensitive referral to a trusted allied health practitioner without having to go through the charade of writing a care plan. (GPs make referrals for X rays, pathology tests, examinations by specialists without having to be paid to do so – why should a mental health referral be seen as especially different?)

(ii) the rationalization of allied health treatment sessions,

It is difficult to achieve consensus over what constitutes a need for treatment in the fields of mental health and mental illness. Specifying the use of focused psychological strategies has been necessary as an arbitrary means of dealing with what is actually a complex challenge for us all. Reducing the potential number of treatment sessions from 18 to 10 is based on a misinformed assumption that only people with mild to moderate disorders are seen under Better Access and that their problems can be resolved in a relatively short period of time. This is not usually the case.

I believe that the number of treatment sessions should remain set at a maximum of 18 per year while every effort should be made to ensure that clients only receive the number of sessions that are needed. In this regard, particular emphasis should be placed on transitioning from 1:1 therapy to small group therapy.

It should be acknowledged that allied health practitioners have not been compensated in any way for the time, energy and skill required to conduct initial and ongoing assessments, write care plans, report back to the referring GP and liaise as much as is needed with other persons engaged in caring for a client – e.g. a teacher, family support worker, GP etc. The need for interdisciplinary liaison was recognized when Mental Health Practitioner Networks (MHPN) were set up throughout Australia. This is all done in the practitioners own time, so there should be no surprise when allied health professionals complain about the lack of remuneration for the services they provide.

(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.

The "two tiered system" not only separates clinical psychologists from psychologists; it also separates social workers and occupational therapists from psychologists; mental health nurses are often overlooked and generalist "counselors" claim they are being devalued – it is a "can of worms." It has exposed the inter and intra disciplinary rivalry and insecurity that permeates our profession(s). I am concerned by this, but it is a fact of life.

My suggestion is that the government perseveres with the system as it is. We in the professions now have something to work with, (or against in some cases!) and I am hopeful that this will eventually produce the sort of rationalization that is needed to make our professions more mature, more secure and more able to tolerate and respect each other.

(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 have already commented on this. I believe it is a mistake to reduce the number of sessions to 10. It assumes that most clients can be helped with brief intervention. This is not the case. Persons who have chronic stress disorders, mood disorders, traumatic histories, disorders complicated by their abuse of or dependence on alcohol or other substances require sustained and recurrent intervention. The withdrawal of services when the ceiling is reached can be seen as an attack on their sense of efficacy and their sense of worth. Withdrawing services because the ceiling of 10 has been reached is unethical and will create dilemmas for most practitioners.

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

ATAPS is a vital program. It started before Better Access and targets those with limited resources and those who have limited access to services. There is NO basis for assuming that ATAPS service providers are able to take up where Better Access stops or that ATAPS staff can deal with clients who are not being managed by the state mental health service. ATAPS staff, working under the umbrella of Divisions of General Practice are no better trained than Better Access service providers and in some cases they are less trained and receive less support and less professional supervision.

More strenuous, deliberate and focused efforts are need to bring together the professionals who work under ATAPS and Better Access, their "colleagues" in the public sector mental health services as well as GPs and psychiatrists. Currently they work in parallel, not in collaboration.

(d) Services available for people with severe mental illness and the coordination of those services.

The care of people who have a severe mental illness tends to be the responsibility of the public mental health service. In some cases where clients have the financial capacity to seek private care, this is done by psychiatrists who work in private hospitals with the assistance of a variety of allied health professionals. The lack of communication and understanding between the public sector services and the private services as well as those in between who work in the non government services (e.g. Divisions of General Practice, Lifeline, Relationships Australia, Neighbourhood Centres etc) is deplorable. It is to be hoped that Medicare Locals will play some part in breaking down to barriers to communication and collaboration that has characterized these services for many years.

(e) Mental health workforce issues, including:
(i) the two-tiered Medicare rebate system for psychologists.

See my comments above. I.e. keep the tiers and press the professions to sort out their differences. We desperately need a wide range of experienced practitioners so it is counterproductive to restrict service provision to the current "clinical" psychologists. In time these distinctions will be easier to make and perhaps our community will have more informed understanding of what constitutes a mental illness, as opposed to a mental health problem which does not require the sort of pathologizing and sophisticated intervention that more complex mental illness such as chronic anxiety, PTSD, depression, psychosis and related disorders require.

(ii) workforce qualifications and training of psychologists.

The profession is working towards the time when all registered psychologists will have a clear post graduate level of training and supervision in clinical services. In the meantime, the psychology profession has a well developed structure for supervising and supporting graduates who complete a 4 or 5 year program at university. Please allow us the time to achieve the goal that we all aspire to, that is, all psychologists will either have a specialist endorsement, clinical, or will clearly be the modern version of a mental health, front line generalist.

(iii) workforce shortages;
See my earlier comments. We can always say that we need better trained staff, but those who are in the field now are doing a good job considering the complexity of society and the human psyche! Universities need greater encouragement (funding) to train practitioners for the real world.

(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;

The mental health needs of people in these categories warrant our attention. One "issue" that affects all of the above plus the rest of the community is that of the misuse and dependence on alcohol or other drugs. I am alarmed at the apparent lack of interest in this overwhelming issue. No longer can substance use be arbitrarily separated from the mental health/mental illness field. These problems coexist and ought to be recognized and treated by professionals who can appreciate this fact. The days of referring "alcoholics" to AA, drug users to the Salvation Army and staying quiet about housewives who are dependent on minor tranquillizers are over, but we still have service structures that reflect this outmoded, nonsensical perspective.

Thank you for taking the time to read my comments. I urge you to preserve and develop the wonderful work that has been started under Better Access.

Yours sincerely,