

Committee Secretary
Senate Standing Committees on Community Affairs

29 July 2011

Inquiry: Commonwealth Funding and Administration of Mental Health Services

My apologies for making this submission anonymously but I have been advised there are threats being made by certain organisations

As a Clinical Psychologist who practiced originally as a 4+2 year trained psychologist before undertaking postgraduate studies and experience over 20 years ago, I wish to comment in relation to the following terms of reference

(b) changes to the Better Access Initiative, including:

Having worked in private practice with GPs, I believe they make a valuable contribution in identifying patients who require mental health services & should be kept informed by the mental health professionals to whom they refer patients.

I do, however, question the appropriateness, in a funds-limited system - of requiring, and paying, GPs to do a mental health care plan rather than simply write a referral letter based on their initial screening of the patient. The plans are also time-consuming for the GP and patient. The clinical psychologist has to assess the same factors GPs assess in the mental health care plan so it is a doubling up of process which costs the community and government in time and money.

(ii) the rationalisation of allied health treatment sessions

I understand the desire to rationalise the number of sessions. However, having been in practice for nearly 30 years, I am aware that the complexity and severity of disorders now presenting to private psychologists has increased considerably. I suspect this is due to a combination of societal factors and a reduction in real terms of the services provided by public mental health services. Having also worked in the public sector, I know that the volume of patients they can see is reduced by the high volume of paperwork, meetings and beaurocratic processes required.

Whilst the majority of psychologists focus on short-term therapy, the reality is that complex &/or severe cases cannot be adequately treated in 10 sessions. 12 sessions at least enabled a strategy of doing intensive (eg weekly) treatment initially, then lengthening time between sessions so that the patient could be seen over a 6 – 12 month period. This allows the therapist to monitor patient progress to either ensure long-term change has been effected &/or to use of real-life stresses to help the patient generalise the skills they have learned in therapy to situations with which they need to deal. This approach enables effective resolution of the patient's underlying problem rather than taking a 'band-aid' approach where the patient is seen for say 7 sessions, then returns to therapy repeatedly as there has not been sufficient change to their coping skills to deal with life stresses as they occur.

I am concerned that the government is proposing to cut sessions and rebates for clinical Psychologists, whilst allowing at least 4 times as many sessions per year for visits to Psychiatrists. Whilst the number of sessions for psychiatrists may be appropriate for patients who have severe, ongoing psychiatric disorders that require long term medication and monitoring, many other patients do not – I have personally seen many patients who report no psychological interventions were undertaken by their psychiatrist, their sessions were

purely a review of medication and coping - these same clients were able to cease medication and demonstrate resolution of their disorder after psychological treatment.

(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

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I do, however, question the appropriateness, in a funds-limited system - of requiring, and paying, GPs to do a mental health care plan rather than simply write a referral letter based on their initial screening of the patient. The plans are also time-consuming for the GP, who usually has many more patients to see. The clinical psychologist has to assess the same factors GPs assess in the mental health care plan so it is a doubling up of process which costs the community and government in time and money.

- (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;

Having worked in both tiers (ie a became a registered psychologist under the 4+2 system before obtaining post-graduate training & endorsement), I am greatly concerned with the concept of losing the two-tier system. I practised as a 4+2 psychologist for 12 years and was surprised to discover how much more I needed to learn and how much my practice was improved by undertaking a masters program in clinical psychology. And, back then, 4th year included more practical components eg proficiency in psychometric testing, supervised placement in the workplace. Current 4 year courses do not include any of these practical aspects. There is a huge difference in *applied* knowledge and supervised practice between the clinical masters and 4-year programs. And as human psychology is a complex area, this difference is important. The Australian Psychology Accreditation Authority and the APS are clear on what subject matter is included at different levels – the 4-year course is simply not aimed at professional training – it is set up as preparation for the professional training provided at masters or doctoral level.

There are 4+2 practitioners, trained at a time when there was a higher practical component to 4th year, who have had long-standing experience and high quality supervision who are very skilled practitioners. They had the opportunity of applying for membership of the specialist colleges within the APS, which required demonstration of the equivalence of their knowledge and skills. Many chose not to do so – that was their choice.

Research purporting no difference in outcome for patients of each tier was seriously flawed & did not examine all the relevant factors (eg diagnosis, complexity etc).

Medical patients have the choice to go to a GP or a specialist – mental health patients should have the same option, with concordant rebates.

(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;

I have worked in rural areas and I am aware of the many difficulties facing rural people in accessing high quality services. I therefore feel it is essential that online and phone-based services be made available to these people and have Medicare rebates accordingly. It should also be noted that there are times after a patient has completed treatment but is not yet fully effective at applying the strategies they have learned, when a half-hour phonecall to assist the client in dealing with a life stressor could address the issue and prevent mental health deterioration which might require more intensive treatment at a later date.

Thankyou for your consideration