Inquiry into COMMONWEALTH FUNDING AND ADMINISTRATION OF MENTAL HEALTH SERVICES

Submission to Enquiry with particular reference to:

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

(ii) the rationalisation of allied health treatment sessions,

(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, and

(e) mental health workforce issues, including:

(i) the two-tiered Medicare rebate system for psychologists,

(ii) workforce qualifications and training of psychologists.

General professional Information of person making submission.

I am a Psychologist registered in Australia and work full-time in private practice. I have a business where I employ three staff and provide rental rooms and administrative services to other Psychologists and other allied health practitioners. The current structure of the business has been operational since 2008. Previous to current structure, I worked full-time renting rooms and services off two Psychiatrists. I have had 20 years experience working as a Psychologist, or in the field of Psychology in Government and Private Institutions and in Private Practice. I am regarded as a Generalist Psychologist according the current guidelines.

The advent of Medicare rebate for Psychologists has allowed more credibility and accessibility by community to psychological services. Before Medicare I had a full-time practice where patients chose to attend using their private health fund for rebate, DVA, Work Cover, or private funds.

Addressing:

(b) (i) and (ii)

I wonder at the rationalization of the allied health treatment sessions. In most psychological research methodology and findings, outcomes are based on a 12 to 18 session programs. I am not privy to the rational however I suspect it would be in consultation with psychologist's knowledge of general research findings for better outcomes, and that research outcomes are based on a 12 to 18 session model.

Therefore I question the rational for the change in (b) (ii)? I question the inference that Psychologists in private practice see "mild to moderate cases". From my years of experience, I have found that GP's try to match their patients needs with the psychologists that they know, their gender, age and expertise. The severity of the mental health issue does not appear to determine who GPs refer to. The need for medication and the GPs guidelines and expertise to prescribe appear to determine whether the patient access Psychiatric services, not the severity in terms of psychological need.

The reduction of accessibility for psychological services for a patient to access only 6 +4 sessions , may affect the outcomes for the patient. As it is now, at times for particular patients, I have to negotiate a fee for the patient to continue therapy after the annual Medicare rebate has expired. To have only access to a possible 10 sessions for rebate exacerbates the problem.

Reduction in Medicare refundable sessions just increases financial difficulties for some patients and may compromise treatment outcomes if therapy is terminated.

How is severity determined? By the K10 that is often used? By the complexity of the issues?

Sometimes patients are extremely distressed with a very high score on the K10, and then with two or three sessions, the score is markedly reduced. Sometimes patients who present with chronic psychological needs have a 'medium' score on the K10, however mental health needs are complex and chronic and usually require long term regular sessions.

Addressing (e) (i) and (ii)

I am regarded as a Generalist Psychologist, therefore patients access the lower tier rebate system for Psychologist when the patient attends. Before Medicare rebate for Psychologists, I was regarded highly in private practice for the services that I provided for patients. Since Medicare rebate was introduced, my standing in Private Practice has been maintained by the GP's that refer their patients to me. The GPs say they cannot see any difference in the outcomes for their patients who are referred to 'Clinical Psychologists" as opposed to me as a 'Generalist Psychologists" . However there are some GP's who fear that there may be legal implications in a Court situation if they refer patients to Generalist Psychologists , when there are Clinical Psychologists available who 'must have' more expertise! I also have had patients who say that they cannot see me because their private health fund will only refund for Clinical Psychologists.

There are patients whom I have seen intermittently over the years, query that I am now seen to be not a Clinical Psychologist when what they were receiving and getting good outcomes with was evidence-based Clinical practice. Some patients now say they only want a Clinical Psychologist.

It appears that the consumer thinks that the Clinical Psychologist is somehow superior to the Generalist Psychologist. From my knowledge there is no empirical evidence of that.

I have been able to get endorsement as a "Counselling Psychologist" which appears to be an Oxymoron in name. I have completed a Master Degree in Mental Health at the Dept of Psychiatry and Psychology, but which course was "not on the list" when the Clinical Medicare panel was reviewing my application for Clinical endorsement. There verbal feedback was that my psychotherapy training was at least equal to or better than the Course structures that were on their

list, but because the course that I did was not on 'the list' it was disregarded. It seems there was no 'Grandfather Clause' in the Medicare assessment team to account for the many years of experience that many practitioners have had managing the mental health needs of their patients.

Registered psychologists are well trained whether they have four years University training plus two years of supervised practice or whether they have completed some form of masters course work . To be registered in Australia and regulated protects the public. Why is there a dichotomy in the two-tiered system which is empirically unsubstantiated in terms of patient outcome and which sets up a better than and lesser than inference on the expertise of the Registered Psychologist.? The Ethical guidelines determine for Psychologists what they feel they can manage and what needs to be referred on. There is no validity in my referring someone onto a Clinical Psychologist as opposed to any other registered generalist psychologist. It is the particular expertise of the individual Psychologist e.g. treatment of Eating Disorder or ADHD etc that would determine referral sources not whether they are Clinical or Generalist.

My Clinical Psychologist colleagues who work in my Practice cannot find anything that differentiates their ability to those of the Generalist Psychologists in the Practice.

In closing I wish to comment that the parameters that determined Clinical and Generalist is questionable and the number of sessions that were determined and subsequently changed to less seems to based on unsubstantiated information.

Further comment as a Practitioner in Private Practice Business that the lower rebate of approx $81 per 50-60min session is not sufficient to pay overhead expenses and acquire a reasonable salary for the Professional, and still have a highly accredited Practice. Just do the sums: if you employ a receptionist during that hour of consultation, have EFTPOS facility, toilet, water, waiting area, paper administration, fees etc, the sums do not add up. If the Senate enquiry were to consider a one tier system of rebate for Psychologists, I hope it would not mean the lower tier. It would mean that a gap fee is absolutely necessary to maintain a high standard practice.