Submission to Senate community Affairs Committee for commonwealth Funding and Administration of Mental Health Services

Terms of Reference:

(b) Changes to the Better Access initiative including:

(ii) **The rationalisation of allied health treatment sessions**

The proposed reduction of treatment sessions from a possible 12 sessions plus an extra six sessions under exceptional circumstances is a very unfortunate proposition for those people who have moderate to serious mental health issues. The people affected by these mental health issues include the population who have ongoing issues due to **past trauma and neglect**. The issues referred to include **Chronic Complex Posttraumatic Stress Disorder** and associated conditions, including **Personality Disorders, Bipolar Affective Disorder, and severe mood and anxiety disorders**.

The **key** to treatment of these complex clients is developing a safe, secure, trusting therapeutic relationship, which can only be developed over time. The possibility of having 18 sessions government funded in one calendar year goes a long way to covering the costs for these clients, who often need more than this. To **reduce these 18 sessions to 10** serves as a severe blow to these clients who often have limited financial resources and struggle to find the extra money to pay for sessions privately even at a discounted rate. At present there is no alternative access to ongoing treatment for these people.

The population concerned involve generational issues that can only be attended to over time and with the support of more than one source. Support being provided to the children of these clients, through the already overloaded community mental health for children with severe conditions and support to those children with mild to moderate issues through the private Medicare funded system. **If we do not attend to the adults with these major issues, then we are more likely to foster ongoing generational issues through the inadvertent, continuing abuse and neglect.**

Treatment and support means that the clients in question are able to remain in the workforce (even if it is only part-time), **or** become available to enter the workforce, providing them with the dignity of work and making a contribution to the community that supports them. This also provides a good role model to their children to pursue the opportunity of their own place in the workforce long term.

I implore you as a psychologist to reconsider this proposal and reinstate the possibility of long term support and treatment of these vulnerable members of our society. It is also useful to look at the recent statistics of just how minimal overall the negative financial impact would be on the budget, while having such a significant positive impact on these clients.

(e) Mental Health workforce issues including:

(i) The two tier Medicare rebate system for psychologists

The proposed removal of the two tier Medicare rebate system for psychologists is of major concern to all clinical psychologists. To date there has been a distinction between generalist trained psychologists and clinically trained psychologists. This is a reflection of the extra study and workplace training, and clinical supervision that has been engaged in by clinical psychologists. The focus of clinical training is of complex mental health issues, including the Severe Mood Disorders such as Bipolar Affective Disorder and Major Depression, and Anxiety Disorders such as Obsessive Compulsive Disorder, Panic Disorder, Chronic Posttraumatic Stress Disorder and severe phobias. These conditions are complex and clinicians require ongoing training and supervision by experienced clinicians to keep up to date with the current most effective methods of treatment. So not only do clinical psychologists initially train specifically to recognise and treat these conditions, they also are required to do extra ongoing training that is not required by generalist clinicians.

The commitment to our clients is considerable and we invest much in our training and work, and therefore expect that we will be remunerated for this. The unfortunate long term effect of reducing all rebates to the one generalist rebate will most likely mean that some clinical psychologists will not see the value in continuing to upgrade their skills using up their precious resources, while they could take the more relaxed pace of doing less and only meeting the generalist standards.

It seems to me that it **is a dangerous path to follow**, suggesting that **specialities are of no relevance**. Each area of specialisation truly deserves a specialist rebate for that which is the specialist domain of that area of psychology (e.g. neuropsychology, health, forensic, family and relationship counselling, community, exercise and sport, education and developmental, and organisational). However, **we must remain cognisant that Clinical Psychology is the only profession**, **apart from Psychiatry**, whose entire accredited and integrated postgraduate training is specifically in the field of lifespan and advanced evidence-based psychopathology, assessment, diagnosis, case formulation, psychotherapy, evaluation and research across the full range of severity and complexity. We are well represented in high proportion

amongst the innovators of evidence-based therapies, NH&MRC Panels, other mental health research bodies and within mental health clinical leadership positions.

It is clear that DoHA has had to follow a government imperative to demonstrate cost savings and that this is non-negotiable. However, it is abundantly clear that the obvious significant gap in mental health service provision is for those in the community presenting with the most complex and severe presentations. This is the unique specialised training of the Clinical Psychologist and, to undertake a comprehensive treatment of these individuals, more than thirty sessions per annum are sometimes required. In this way, Clinical Psychologists could be treated as Psychiatrists are under Medicare as both independently able to diagnose and treat these client cohorts within the core business of their professional practices.

As a concerned clinical psychologist I ask that the senate committee consider just how significantly this proposed change will make to the delivery of mental health of society's most vulnerable citizens.

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