26 July 2011

Re: Senate Community Affairs Reference Committee Inquiry into Commonwealth Funding and Administration of Mental Health Services

Dear Sir/Madam

As a psychologist (Member of the College of Clinical Psychologists) with over twenty years of clinical experience, I write to express my concerns about the Federal Government's proposed cuts to the *Better Access to Mental Health Care Initiative ("Better Access Initiative").*

For ease of your consideration, I have summarised my concerns in a number of areas, as noted below -

1. **Conceptual Implications of Funding Cuts and the Fragmentation of Mental Health Services into Discontinuous Treatment Programs (ATAPS)**

Whilst the Government is to be commended on its recent budgetary increase in mental health spending, it is somewhat disturbing to find that this is perhaps to be at the expense of the existing Better Access Program which, situated at the primary health end of the health care spectrum has marked the start of a conceptual shift in mental health reform – the first that I have witnessed over the many National Mental Health Plans that have been developed. Specifically, the move toward GP based services placed mental health within a broader context, enables the treatment of psychiatric disorder to be more comprehensively treated within the context of broader contributory factors, including physical conditions, familial and interpersonal dynamics, employment circumstances and the like. As a result, it has made available access to the specialist profession of Clinical Psychology, thereby providing the public with non stigmatising mental health service provision. Indeed, it has been my observation that the provision of the "mental health care plan" per se has led many to have to re-conceptualise their understanding of mental health and perhaps to recognise it more as a continuum along which we are each situated rather than a category in which there are those who are "the mentally ill", and the rest of "us". In my opinion, in the longer term, it is structural changes such as was made available through the Better Access Program that will alter community attitudes toward mental health, truly aligning it with the mainstream mental health services and providing people with self driven choice as to who they choose to consult.

Thus, it is also of deep concern that a proposal has been made to provide referral to a second program – ATAPS, in the event that people are defined to have more complex needs. Such a response to the ongoing and more complex needs of some individuals will serve only to perpetuate a system in which people become increasingly demoralised and institutionalised as they find themselves subject to discontinuity of service provision and a fragmentation of the very relationships in which treatment gains are made. Further, with regards the question of stigmatisation, as discussed above, such a prescriptive and directive approach to service provision will only serve

to once again segregate those determined to have greater needs. Ironically, it was my observation over sixteen years of service provision in public mental health, that it was the very fragmentation of service delivery and lack of continuity that led many service recipients to increasingly lose hope as they were confronted with the dilemma of whether to bother re-engaging with yet another service provider only to tell their account once more. What many perceived to be a sign of illness, I perceived to be a reasonable response in what were all too often unreasonable circumstances. Thus, for reasons of stigmatisation, the maintenance of a conceptual shift toward a primary health care model, and continuity of relationship and service I would urge the Government to reconsider its current proposal to both reduce sessions to the *Better Access Program,* and to begin the process of "carving up" services in what becomes at the clinical face of service delivery a counterproductive effort to assist those in greatest need.

2. **The Reduction of Services from 12 sessions per year (with an additional 6 under exceptional circumstances) to 10**

Having come from a public sector background, and having a commitment to psychology as a social service, I have divided my practice up to enable it to be both financially viable for both myself and those who attend, and accessible to those who are disadvantaged. Thus, I have charged a $27.00 gap to those who can afford to pay, and I also provide bulk billing (30% of my case load) to those in financial hardship.

I work in private practice in the Western region of metropolitan Adelaide. It encompasses a number of low socioeconomic suburbs. A large proportion of my case load is thus comprised of people who have multiple issues in addition to their complex psychological problems. This includes – poverty, long term unemployment, physical disability, gambling, domestic violence and drug abuse. Thus, the *Better Access Program* has enabled me to continue offering my service to people who are disadvantaged, many of whom are otherwise unable to access already stretched public health services. Indeed, my work frequently involves liaison with the mental health services in order to ensure that client needs are met. Where clients with whom I am working have required hospital admission, they have been subsequently referred back to me by mental health services who cannot themselves provide follow up service, and I am happy once again for reasons of continuity to provide what sessions are available, though I am restricted by the cap to the number of sessions.

From the outset, I understood the *Better Access Program* to have defined a set number of sessions, and I have sought to work within these requirements, keeping to an absolute minimum application for Exceptional Circumstances. Such application has usually been made where I have concerns over the active suicidal potential of an individual or as circumstance has seemed to warrant it – for instance, where there has been an <u>unexpected</u> crisis in the employment or familial life (death, separation) of an individual. Thus, I have defined exceptional circumstances in terms of crisis oriented needs and have made minimal applications accordingly. From a therapeutic perspective this has proven difficult at times, given the extent of people's needs, but I understand it to have been a necessary restriction made by the Government in setting the program up. However, the proposal to reduce sessions to 10, with no allowance for Exceptional Circumstances will prove clinically restrictive in what were already rationed services, most especially for those with complex needs for whom I have to date been able to provide a bulk billing service.

3. The Proposed Elimination of the Two Tiered Rebate Schedule for Four Year Graduate Psychologists and Clinical Psychologists

3.1 Professional Qualifications and their Industrial Recognition

As the Senate Committee is no doubt aware, the field of psychology has within it nine specialisations, contingent upon one's academic training and qualifications. Clinical Psychology is one amongst these and as such recognised in through the Australian Psychological Society's (APS) College of Clinical Psychologists which provides for the ongoing network, educational and professional needs specific to those with a qualification in Clinical Psychology. To quote previous advice no doubt provided by the APS to the Senate Committee –

"no other discipline receives as advanced training across the lifespan and the entire spectrum of complexity, severity and range of mental health disorders as the Clinical Psychologist". Ours is the only "Allied Health" discipline whose entire postgraduate training is in the field of advanced evidence based and scientifically informed mental health assessment, diagnosis, case formulation, consultation, treatment, evaluation and research. As such, the Clinical Psychologist is frequently referred the most complex and severe mental health presentations".

Thus, not only does the initial training of General and Clinical Psychologists differ, but also their ongoing development and exposure to matters of clinical practice. In recognition of these differences, it is my understanding that bridging courses are now available to those who completed their training through four years of course work and clinical supervision.

The specialist qualifications of Clinical Psychologists have been recognised through the National Health Service Review (1989) which recognised that only Clinical Psychologists operate at the most complex of skill levels, flexibly providing therapeutic services in a creative way to solve problems in clinical settings. This was defined by the review to comprise Level 3 skills, unique to Clinical Psychologists and involving a capacity to provide –

"*specialist psychological intervention, in circumstances where there are deep rooted underlying influences, or which can call for the disciplinary capacity to draw on a multiple theoretical base, to devise an individually tailored strategy for a complex presenting problem. Flexibility to adapt and combine approaches is the key to competence at this level which comes from a broad, thorough and sophisticated understanding of the various psychological theories"*

(National Health Service Review, 1989, quoted – APS – 4/7/2011).

As such, the specialisation of Clinical Psychology is internationally recognised, and is embedded within Australia's Industrial Relations Awards, the Work Value Document of the Industrial Relations Commission having endorsed the higher industrial work value of Clinical Psychology than of the more generalist qualification of Psychology.

3.2 Current Rebate Provisions

Whilst I have been, and will remain, grateful to the Government for its provision of Medicare rebates for Clinical Psychologists, now is an opportune time to provide comment upon the economic viability of providing such a service as an individual service provider.

Whilst the rebates have provided for 30 and 50 minute consultations, in actuality, in addition to the time spent with the client, each session additionally entails the administrative task and professional requirement that sessions be recorded. Each case note takes me 30 minutes to complete, and in addition about 6- 8 minutes is spent in preparing the coming sessions (I review my notes). Thus, for every 50 minutes that is funded, I provide 80 – 88 minutes of service (if needing preparation for coming sessions). In addition, the review reports required after six sessions remain unfunded and require approximately 1 – 1 ¼ hours, again as I review my notes, and a comprehensive report is provided. Further, effective clinical practice necessarily entails liaison with other professionals and persons in the client's life (with consent). This activity is also unpaid. To date, I have not bothered to calculate the actual hourly rate for the work I provide which is personally remiss of me. I have been aware, however, of the dramatic reduction in my income following my departure from the public sector, in which I also received Annual, Sick Leave, Long Service Leave and Salary Packaging remuneration. The notion that private practice is financially lucrative is misguided, and the APS guideline that the hourly rate of a psychologist is $216.00 is more realistic. Private practice (aided by access to Government funding) has, however, proven to be a satisfying and rewarding way in which to continue practicing the profession to which I am committed. Thus, I again thank you for providing the rebates that have been made available and request that the two tiered system of rebates not be abolished.

In the event that the two tiered system is scrapped, the service I have been providing will no longer be viable, and will of necessity be brought to a close. Whilst I may be able to sustain some services to those able to afford a significantly larger gap, this will unfortunately not be the case for those who are financially disadvantaged.

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I trust that this submission will be of assistance to the Senate Committee in its deliberations on the *Better Access to Mental Health Initiative.*

With Kind Regards

Helen Gibbs