

Terms of Reference

The current submission pertains to:

1. The changes to the Better Access Initiative including:

* 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 (reduction from 18 to 10 sessions)

2. Mental health workforce issues including:

* the two-tiered Medicare rebate system for psychologists

1. The changes to the Better Access Initiative from 18 sessions to 10

This submission is being tendered on behalf of the Life Promotion Clinic staff and has the overwhelming support of our clients and their families. Whilst some of our clients have the ability to endorse an independent submission, we feel that the most vulnerable group lacks the capacity to advocate on their own behalf or may be at risk of emotional harm from engaging in such a demanding procedure. To them, our clinic is an essential service and in many cases literally a “lifesaver”. We therefore would kindly appeal to the Senate Committee to also consider our submission as bid to advocate on their behalf.

Our practice, Life Promotion Clinic (based at Griffith University, Mt Gravatt), specialises in the treatment of suicidal clients and individuals who engage in deliberate self harm. The clinic is part of the Australian Institute for Suicide Research and Prevention and is the only outpatient service in Australia dedicated to the follow up and treatment of individuals with a history of suicidal ideation and behaviour. It is also part of a World Health Organisation (WHO) accredited research facility. It is a private, bulk billing-only clinic for all our clients, and we receive no other forms of funding except Medicare payments.

This submission outlines the anticipated consequences of the proposed changes directly and adversely affecting our ability to adequately provide a suicide prevention and treatment service. The Better Access Initiative has been criticised by some, for being focused on the “worried well.” Life Promotion Clinic is an example where disadvantaged people with complex presentations can be treated within a timely manner. This submission specifically outlines how our clients will be affected, however where possible we have attempted to incorporate how the changes affect all clients of Psychologists/Clinical Psychologists.

Our team is multidisciplinary, incorporating Psychiatrists, Psychiatry Registrars, Clinical Psychologists, a Psychologist, and a Mental Health Nurse. As a result of the high suicide risk our clients pose, many require both a Psychiatrist (to manage medication) and Clinical Psychologist/Psychologist (to deliver the interventions) involved in their care. We monitor our clients’ risk and functioning at assessment, and follow up intervals, and conduct research into the effectiveness of our interventions. Statistical analysis showed that at the time of their first appointment, the majority of our patients reported an active or passive desire to kill themselves (70.2% and 63.2%, respectively). 80.7% of patients reported they had attempted suicide at least once in their life and 78.4% of these reported two or more suicide attempts. More than half of the patients presented with severe levels of hopelessness, extremely severe depression and anxiety (56.2% and 51.2% respectively), and nearly half of them rated their quality of life as ‘poor’ or ‘very poor’ (45.9%) on validated assessments measures. This profile suggests that clients of Life Promotion Clinic are people who remain at high risk for

subsequent suicidal behaviour. As our clients predominantly come from lower socioeconomic groups, or due to their mental illness are unable to work, all of our clinicians have decided to offer treatment as a gap-free, bulk billing service for all our clients._

Overwhelming, the scientific evidence shows that treatment of psychiatric conditions leading to or increasing the risk of suicide is complex and requires consistent long-term support. Therefore you will understand that we are very concerned at the proposed changes reducing the number of sessions our clients will have access to. Clients will go from being able to access a Clinical Psychology/Psychology session once every 2.88 weeks (based on a 52 week year), to only being able to access their Psychologist once every 5.2 weeks. Based on 18 sessions per year, our team has been able to manage the risk of suicide these clients pose. However, with a reduction in session numbers, clients' suicide risk will become less manageable.

By reducing clients' access to Clinical Psychologists/Psychologists, it is almost certain that there will be an increase in psychiatric hospitalisations at public facilities. Hospitalisation, and/or return to work programs involve significant expenses when compared to the cost of Clinical Psychology/Psychology sessions at an outpatient clinic. Additionally, it has been reported in the literature that inpatient admissions can result in further deterioration of an individual's mental health, and admissions can cause regression in individuals with certain personality disorders, such as Borderline Personality Disorder. At the very best, an inpatient admission still does not address the underlying needs of the individual, and after discharge individuals often do not receive the level of follow up they require in order to reduce further hospitalisations. It is important to note that follow-up care after presentation to hospital for those who attempted suicide, was found to reduce the rate of subsequent suicide compared with a control group (Mann *et al.*, 2005). Recognising that people with a history of suicidal behaviour represent an important target group for suicide prevention, it is not surprising that most of our clients (over 500 since 2004 when the clinic was opened) have previously received treatment by a public mental health service. This includes public hospitals, and overwhelmingly clients report being highly dissatisfied with the treatment received, because there are not enough resources to meet the needs of these highly distressed individuals. There is also the issue of stigma associated with inpatient psychiatric admissions.

The suicidal clients treated at our clinic are referred from public hospitals, Acute Care Teams, General Practitioners, other Psychiatrists, and other Clinical Psychologists/Psychologists who are unable or find it difficult to adequately manage the clients' risk factors with the resources they have access to. The clinicians at Life Promotion Clinic are responsible for assessing, diagnosing, and treating the most vulnerable, and most at-risk patients. We are able to offer services to people who otherwise may not have ongoing access to services – they have high prevalence disorders such as anxiety and depression and are not accepted into public mental health services (or their files are closed after a brief period and treatment is declined); and they are unable to seek help in the private system generally because the costs are too high. The analysis of the characteristics of our clients showed that the majority were unemployed, or out of labour force, and hence they are restricted financially. Therefore, for many people, our clinic offers the only viable option for treatment.

Although clients have the option of seeing private bulk billing Psychiatrists, the cost of this often exceeds the treatment costs of Clinical Psychologists/Psychologists. Additionally, the majority of Psychiatrists in Australia spend their sessions with clients identifying the best psychiatric medication/s to meet the unique needs of the clients. Thus the exploration of

existential issues and life events is often minimal, given the standard timeframe of a psychiatric consultation. Also, the time spent on teaching clients skills to manage and overcome their difficulties is also restricted due to the same time issues. It is noted that there are no proven psychopharmacological treatments that prevent suicide.

By reducing the number of sessions, this will result in an increase in the personal liability risks of any Clinical Psychologists/Psychologists who work in a private practice model. Many Psychologists choose not to work with suicidal individuals due to the risks and potential legal implications, and limiting session numbers will only serve to decrease the number of practitioners willing to accept this risk.

At Life Promotion Clinic, most clients have access to a Psychiatrist (or Psychiatry Registrar) and a Clinical Psychologist/Psychologist based on consideration of their needs, as this has been the model that has been successful in preventing suicides at this clinic. If sessions reduce to 10, this will increase the pressure on our Psychiatrists to pick up clients who have had to finish with their Clinical Psychologist/Psychologist (as we bulk bill only, and do not offer further sessions for personal payment). As a result, the clinic will not be able to see the volume of clients that we do currently, which will reduce people's access to our specialist services. As a training facility for Psychiatry Registrars, case managers, and other allied health practitioners working both in the public and private systems, with additional pressure on our Psychiatrist (and Registrars), the availability of time for teaching and supervising others how to treat suicidal clients will reduce. This will have an impact on the number of clinicians trained in how to prevent suicidal behaviours.

As a WHO accredited research facility, the change would also affect our research as we will have reduced numbers of clients, and potentially less power in research analyses. This research is important, as by collecting vital information about the outcomes of the treatment, this contributes to the development of the best possible protocols of clinical practice to counteract suicide and suicidal behaviours. To the best of our knowledge, in addition to our clinic, there is only one other project in Queensland that is concerned with continuing care of people with a history of suicidal behaviours (The Queensland Health Emergency Department Follow-up Care Pilot Project).

We therefore urge you to re-instate the 18 sessions of Psychological therapy per calendar year.

2. The two-tiered Medicare rebate system for psychologists

It has been proposed that the two-tiered Medicare rebate for Psychologists/Clinical Psychologists be flattened to the one lower rate. There are a number of concerns that arise in relation to this that affect Life Promotion Clinic and the profession in general, which are outlined below.

- * It will further disadvantage clients who cannot afford to pay gap payments, as private Clinical Psychologists will be forced to charge these gaps rather than bulk billing, otherwise it would not be financially viable.
- * The reduction in rebate devalues the specialist skills that Clinical Psychologists have, and the extensive training and professional development that they have undertaken and continue to engage in.
- * Health care legislation and care providers in the UK and the United States have recognised the specialist skills that Clinical Psychologists acquire from their training, as has the Industrial Relations Commission in Western Australia. If Australia was to make every

Psychologist a generalist, regardless of their level of education, expertise, and specialisation, this would be a backwards step in relation to world-wide standards.

- * Many Psychologists do not want to work with clients who are suicidal, as this work represents high risk personally, professionally, legally, and financially. Additionally, most Clinical Psychologists/Psychologists do not want to work in bulk billing practices, preferring to charge gap fees.

- * For Psychologists, the two-tiered system gives another level of remuneration to work towards, instead of a glass ceiling effect of only one level of pay, regardless of level of training and expertise.

- * There will be no financial incentive for Psychologists to continue post graduate education if the two-tiered system is abolished. Given that post-graduate programs cost in the vicinity of \$30 000 for three years, why would Psychologists want to continue training to become a Clinical Psychologist if they are not compensated for this at the end of their training? It should be noted that post-graduate training is the only standardised and accredited pathway to equip psychologists with skills essential for safe and competent treatment of high prevalence and complex disorders. In the medical profession, specialists are compensated at higher rates than general practitioners, recognising the continued training the specialist has acquired in their field. Clinical Psychology is the only mental health discipline, apart from Psychiatry, whose entire accredited training is specifically focused in the field of evidence-based assessment, case formulation, diagnosis, and evaluated treatment of the full spectrum of lifespan mental health disorders across the full spectrum of complexity and severity.

- * Overall, it is likely that abolishing the two-tiered system would result in de-skilling of the industry, and potentially poorer outcomes for clients.

- * It would create difficulties in recruiting Clinical Psychologists to Life Promotion Clinic, as this is a bulk billing clinic and clients will not be able to make up the cost difference from \$81.60 to \$119.80.

- * It would potentially reduce staff retention, as Clinical Psychologists may prefer to work at clinics charging a gap fee, rather than accepting the lower rate of pay.

Therefore, on behalf of our team and our hundreds of clients, their families and friends, we urge you to continue the two-tiered Medicare rebates, and the 18 sessions of treatment per calendar year.

