

Friday, 5th August, 2011

Committee Secretary
Senate Standing Committee on Community affairs
PO Box 6100
Parliament House
Canberra ACT 2600

Dear Committee,

Submission to

Senate Community Affairs References Committee

Inquiry into Commonwealth funding and administration of mental health services

I appreciate the opportunity to make this submission, which while brief, expresses my deep and serious concerns related to proposed changes to funding for mental health services, particularly as delivered by Psychologists and attracting a Medicare rebate.

My comments come in the context of my own personal and professional background. I am now a Clinical Psychologist in full time private practice but previously, I worked as a Registered Nurse and Midwife, almost exclusively in the public sector. My comments are made therefore with a depth of experience at the “coal face” of health care delivery in university teaching hospitals, mainly in Australia but with some experience in the United States and primarily in the areas of Emergency, Critical Care and after hours Nursing Administration.

While the increased funding flagged for mental health in the most recent budget can only be welcomed, I have significant concerns regarding the way in which that funding is to be allocated. My two main areas of concern are;

1. Better Access Initiative

The reduction in the number of sessions eligible for a Medicare rebate.

Currently 12 sessions in a calendar year are rebated, with possibility of a further 6 sessions in what is deemed to be “exceptional circumstances”. This is to be reduced to a maximum of 10 sessions in a calendar year.

This proposed reduction is based on what would appear to be inaccurate perceptions and inadequate information and represents an added burden both for the client and the treating Psychologist. The comments and observations that follow are based on my own experience, experience which has been echoed in extensive discussions with several similarly qualified and highly experienced colleagues

- The Better Access model was proposed for those with mild to moderate difficulties.

While the Better Access Initiative (BAI) may have been aimed at a particular population it has in fact been tapped into by many who have more severe psychological difficulties. These were people who were unable to get care elsewhere in the public or private sector or people for whom psychological care was out of their financial reach. At this point only limited research has been undertaken to determine severity and outcome and what has been done so far has not had sufficient sensitivity or specificity to demonstrate the reality of many private practices. To illustrate, a General Practitioner may refer someone with an anxiety disorder and in the course of therapy previously undisclosed childhood trauma is disclosed and has to be addressed. For statistical purposes, such a client's diagnosis, severity of psychological difficulty and outcome would be seen as an anxiety disorder a classification that would not be adequately or accurately represented the clinical reality.

The uptake of the Better Access Initiative has been much higher than expected, and as such, much more expensive. This uptake should however be seen as an indicator of the depth and extent of unmet need for adequate mental health care in Australia as well as evidence of chronic under funding of the mental health sector. So many people presented for care because so little had been available previously.

- The Better Access Initiative has resulted in a concentration of services in urban and/or otherwise well resourced areas.

It is true that there are more Psychologists available in urban areas but that does not mean that those presenting for care in urban or affluent areas are not in need of that care. Psychological disturbance, like physical illness, is no respecter of geography or post code. There is in deed a crying need for more services in rural and regional Australia and that is true for all levels of health care. Further, location does not necessarily correspond to the demographic of those using that care. My own practice is located in a more affluent area of Sydney however at least half those in my practice are in receipt of Centrelink benefits, are students, single parents or low income earners and many come to my location because of my proximity to public transport or their place of work.

- Those with serious mental illness are better cared for elsewhere.

As a Clinical Psychologist I frequently see people with eating disorders, addiction and substance misuse, perinatal depression and anxiety, the spectrum of personality disorders, self-harm, post traumatic stress disorder and psychotic illnesses as well as less severe difficulties including grief, adjustment disorders and those with intercurrent medical problems such as chronic pain in cancer, in addition to those with moderate to severe anxiety and depression. The majority of the clients I see are not at the mild end of the spectrum of psychopathology. They are very often patients who would otherwise be seeing a Psychiatrist and if that were the case, they would have a much more generous and flexible access to a Medicare rebate. It is very difficult, even in metropolitan Sydney, to find a Psychiatrist who does long term psychotherapy who is in a position to take on another patient with limited means. It is also the case

that very often the mainstay of psychiatric care revolves primarily around psychotropic medication. Many Psychiatrists place less emphasis on psychotherapeutic interventions even though the research amply shows, it to be at least as effective and often more so when used in conjunction with medication.

For many of my clients there is no “elsewhere” for them to be treated. Community Mental Health Services (CMHS) are totally overburdened and have little or no capacity for ongoing psychotherapy and their limited resources are focused mainly on crisis intervention. Even after a suicide attempt CMHS will usually only stay involved until risk is deemed to have diminished. Again, in my own experience, I have seen clients in my practice who have been discharged by CMHS because they are no longer actively suicidal though they remain severely depressed.

For those clients whose difficulties complex or severe, six or even eighteen sessions are not enough. There is very little available in the public sector and great difficulty in accessing psychotherapy with a Psychiatrist in a position to provide it. Given my training and experience I am able to offer specialised care to those with severe mental illness in my practice. I also can work as part of a treating team. In the case of clients with an eating disorder I do work in a team in which I do ongoing therapy, a Psychiatrist manages psychotropic medication and any need for hospitalisation, a General Practitioner monitors physiological health and a Dietician monitors food intake and eating plans. My eating disordered clients however have the burden of having to fund their own therapy once the Medicare rebate is exhausted. I am limited as to who I can take on as I am limited by the number of low fee therapy places I have available.

Psychotherapy at adequate depth, for adequate duration and with the necessary Medical and Psychiatric input can be extremely beneficial, to individuals and families. In addition to reducing the burden of suffering it can improve wellbeing and productivity and greatly reduce the need for hospitalisation and the occurrence of “revolving door” chronic psychiatric disability. Reducing the number of sessions with a Medicare rebate might provide a limited and short term saving but is likely to be a false economy and will often result in the further disadvantage of those with most need and those with least ability to pay for the care they require and should be entitled to.

2. The two-tiered Medicare rebate system for Psychologists

An examination of the different rebate available for generalist Psychologists and Clinical Psychologists

I will again speak from my own experience. I have and Honours degree in Psychology and a Masters degree in Clinical Psychology. My undergraduate degree equipped me with knowledge of the academic discipline of Psychology and research methodology. Had I obtained registration as a Psychologist following my undergraduate degree and a period of supervised practice and further learning in an apprenticeship-style training, I would have gained a particular skill set, primarily in the workplace. Instead, I obtained my registration as a Psychologist while undertaking theoretical and clinical training at tertiary level. That training was focused entirely on the understanding of psychopathology across the lifespan and a variety of treatment modalities, extensive and varied clinical placements and included

a research project and dissertation. That training equipped me with a breadth and depth of skills and knowledge in the areas of assessment, diagnosis, treatment, and clinical practice. That training does not necessarily make me a better (or worse) clinician than a generalist Psychologist but I am more thoroughly trained and therefore better equipped to deliver a more in depth therapy to a population with more complex difficulties. As a result I can and do take on more complex cases in my private practice and, as previously stated, see clients would otherwise be in the case load of a Psychiatrist (the only other group of mental health professionals whose entire post graduate training is focused on the assessment and treatment of psychopathology).

The training and skill set of a Clinical Psychologist is different to that of a generalist Psychologist and is specialist level training. That training and skill set equips the Clinical Psychologist to treat a more complex case load and to contribute more to the care and management of those with complex mental health difficulties and as should attract a higher rebate, as with Medical specialists. Undoubtedly specialist level expertise can be gained in other and broader ways than by obtaining a post graduate specialist degree in Clinical Psychology but that is a matter that needs further attention by the appropriate professional bodies and the Australian Health Practitioner Regulatory Authority.

Further Observations and Recommendations

The Better Access Initiative has made a good and significant impact on the chronically under- resourced mental health sector. Many of those who had previously gone untreated, or where unable to access adequate mental health care, have an opportunity to do so and in numbers that exceeded the planning estimates. This is not a reason to cut the service available by cutting the number of available sessions but an opportunity to rethink delivery.

- Greater funding and expansion of public sector programs is to be welcomed, however, even with a massive injection of funding in that system, there is not sufficient capacity to manage the volume and level of need. While this may change over time, it will be a long time before that capacity is anywhere near adequate. Very often public sector programs are only able to assess clients and then refer them out to the private sector. This can look like and increase in client services but it is often the case that much of that load falls outside the public sector, and at the client's expense, if in deed they have any capacity to pay for the care they need.
- Could I also bring to the Committee's attention research recently published in the general media regarding the very high number of Australian women who have experienced sexual assault and/or abuse. The report highlighted what those of us in practice know all too well, namely that such a history brings with it very high rates of mental illness and suicidality. My practice is adjacent to a major teaching hospital where the Sexual Assault Unit has a catchment area with a population of 1,000,000 people. Their part time staff complement cannot possibly cover the need and I am one of the private practitioners they refer too. It is very often the case that a specialist units like the one I mention can only assess their clients and then refer them out. A

limited number of Medicare rebated sessions is insufficient support for these women and cutting what little is available is a great disservice to them.

- Once Medicare support is exhausted my client and I are placed in a very difficult position. Clients with more complex difficulties are often those most in need, and those with the most meagre resources to access the help they need. If they meet the criteria, clients may be able to continue to see me under Access to Allied Psychological Services (ATAPS) programs. This program is also limited to a maximum of 12 sessions per year and remunerates me at a rate lower than bulk billing Medicare. When ATAPS is exhausted or unavailable things then become more difficult. As a consequence I have several clients that I see for token fees of between \$10.00 and \$50.00 per session. Six, twelve or eighteen sessions is insufficient for someone with an eating disorder who is self harming and significantly depressed or someone with HIV and recovering from drug and alcohol addiction. Patients with similar levels of complexity are not uncommon in private practice and are not at the mild to moderate level of psychopathology.

I have recently received a new contract as an ATAPS provider. (Could I also remind the Committee that ATAPS, while providing considerable assistance is delivered via another layer of bureaucracy and infrastructure separate to Medicare and is in itself an added cost.) One of the exclusion criteria that now appears in my new contract is for patients whose primary diagnosis is a personality disorder. With a very disabling psychological difficulty such as a personality disorder, and usually significant other risk factors, where does such a client go when they can't be seen by CMHS, can't find a Psychiatrist with a space for them, can't get ATAPS and can't afford to see me for more than a relatively short period of time?

- Rather than reduce the Medicare support there could be a significant improvement in the mental health care available to very many clients with more complex difficulties if there was an increase in number of sessions rebated. Currently, my patients are disadvantaged because they see me, a Clinical Psychologist, and not a Psychiatrist. Access to a psychotherapy item number similar to that available to Psychiatrists allows many more rebated sessions (Item 319 can make up to 220 sessions available per year for a Psychiatrist's patients) than that available to Clinical Psychologists could make a significant and rapid difference. It would make it possible for me to see more patients in the more complex category, allow me to make my skills more fully available to those in need of them and make more long term psychotherapy places available for those who are currently have little or no access to them.

I appreciate the opportunity to share my thoughts and experience with you as you deliberate these vitally important areas.

Bernardine McDonald MAPS