LifeConnect
ENRICHING LIFE

Committee Secretary Senate Standing Committees on Community Affairs
PO Box 6100 Parliament House
Canberra ACT 2600 Australia

Thursday, 4 August 2011

Dear Members of the Senate Standing Committee,

My name is David Baldwin and I am a provider of Mental Heath Services under the Better Access initiative. I am a full Member of the Australian Psychological Society (APS), a Member of the APS Clinical College and a Member of the APS Counselling College. I am also Managing Director of LifeConnect Australia Pty Ltd, a firm of Psychologists located in North Sydney. Additionally I am an Honoury Associate of Macquarie University. In this capacity I have provided field supervision and training for over twelve years Intern Counselling Psychologists on the Master of Counselling Psychology, and currently I provide supervision to Intern Clinical Psychologists on the Master of Clinical Psychology program.

I have been in private practice as a psychologist for over 30 years treating both children with severe disabilities and adults with moderate to severe mental disorders. I believe that the Better Access initiative is the single most important innovation by any government to provide urgently needed high quality services to those in our community suffering mental illness.

In 2006 I met with Hon Joe Hockey (who was holding Medicare as one of his portfolios) together with David Stokes (APS manager of professional issues) to help advocate the need for psychologists to support the mental heath workforce. I fully endorse the Better Access Initiative as it is, but I recommend some important enhancements.

All clinically practicing psychologists are now at the coalface supporting this still disadvantaged group of people struggling with debilitating mental illness. We are supporting too the severely overstretched public mental health services.

In the past year alone my colleagues and I at LifeConnect have provided services in our local community to 431 patients. The majority of these patients were referred by medical practitioners under the Mental Health Care Plan. These are patients suffering from moderate to severe symptoms of disorders such as depression and other mood disorders, various forms of anxiety, and personality disorders (i.e. patients with both Axis 1 and Axis 2 disorders). These are people in our community struggling to hold down jobs or keep their families together, or just trying to manage day-to-day life. Some of these patients had attempted suicide; others had such acute symptoms that they could no longer manage their studies or demands in the workplace or the responsibilities of a family. As is the case with all of my colleagues, we have documented evidence of supporting these patients to manage their lives more effectively and reduce the presenting symptoms. **These are the people for whom the Better Access initiative was intended and it is working**.

I will leave the calculation of the contribution of this work to the economy, by supporting people to be more productive in their lives, to those with suitable skills.

The two-tiered Medicare system is not perfect but it is a valuable contribution to Mental Health services. In our practice the two-tired system allows us to provide cost effective treatment. We can provide "Generalist" services through well-trained intern psychologists who are completing the Psychology Board, and APS requirements towards full registration as Clinical Psychologists or Counselling Psychologists. The higher rebate for Clinical Psychologists allows us to provide "Specialist" services at the highest standard of evidenced based practice to complex and demanding cases. We have documented evidence of patients treated by our clinical psychologists some of whom have suffered for years without having had access to effective treatment.

Abolishing the "Specialist" status would only exacerbate the already acute workforce shortage by making psychologists incomes even less desirable.

I am well aware that there are divisive opinions about the current two-tiered Medicare rebate system. It is understandable that psychologists with different specialist training see the issue from their differing viewpoints. I am privileged to work with psychologists who have undergone different specialist training. I would advocate that the different specialist trainings each deserve their acknowledgement under the two-tired system. For example in our practice some of the Counselling Psychologists provide *specialised* and highly effective treatment to patients presenting with certain co-morbid symptoms or Axis 2 disorders. At times we need the services of the highly trained Neuropsychologist. As a team we are able to treat very complex and demanding cases in cooperation with our medical colleagues. Not recognising the other specialties especially counselling psychologists is financially unjust and unfair to their patients and themselves.

To reduce the number of sessions available from 12 plus 6 to 6 plus 4 would be inimical to the wellbeing of patients and would risk rendering our valuable services useless. There is ample research evidence to support my statement. In fact there is research evidence to suggest that the average number of sessions necessary to bring about stable change to patients suffering chronic moderate and severe symptoms is longer than the allocated 12 sessions currently available.

The Better Access system is addressing the needs of treating patients with Mental Health disorders. By contrast the ATAPS system is unreliable, complicated for us to use and burdensome in its administration. If there is cost cutting, the ATAPS should be cut and definitely not enhanced.

If further rationalisation or cost cutting is necessary the expensive General Medical Practitioner referral system (Medicare items 2710, 2712 & 2713) should be abolished. General Medical Practitioner can then simply write a referral to Psychologists after a brief consultation as they do to other specialists to whom they refer. Several of the medical practitioners with whom we work closely have concurred with us on this viewpoint. There would be no loss to the quality of patient service. Clinical Psychologists and Counselling Psychologists are highly trained in being able to make a proper diagnosis and treatment plan as part of our work. Currently the patient assessment work is unnecessarily replicated, firstly by the referring G.P. and then again by the treating psychologist. This would save time for the busy G.P s and spare the budget for urgently needed face-to-face treatment for patients.

Yours faithfully,

David Baldwin
Director
Clinical Psychologist