Claudia Michels
Clinical Psychologist, MAPS

Submission to Senate Inquiry into Mental Health Services

Dear Sir/ Ms,

I wish to express my concern and opinion about issues regarding the intended changes to the Better Access to Mental Health scheme. I wish to address your considerations to reduce the Medicare rebate for clinical psychologists to the rebate for psychologists without specialisation.

In a nutshell I recommend:

- Flexible access to clinical psychologists/ allow for assessment by clinical psychologists. This will save the GP rate for assessment.
- Acknowledge that clinical psychologists have a better understanding, and more expertise in addressing complex issues and in some cases a more efficient way of addressing common mental health issues by keeping a two tier payment system.
- Keep the specialisation and therefore higher quality of training and service by paying adequately for the difference in training and ongoing professional development
- Allow for more sessions per client for complex presentations (up to 30 per year) with clinical psychologists only
- Keep 12 (+6) for psychologists without specialisation and for clients with less complex presentations
- Allow for team work and co-ordinated care initiated by the clinical psychologist by adding MBS items reflecting phone consultation, team consultation with other practitioners/ agencies, case conferences.

To understand the recommendations please consider the following explanations based on 18 years of clinical practice:

Some of my clients are being referred to my private practice because other services including general psychologists were unable to help the clients sufficiently. Psychologists without specialist training are not trained to diagnose or recognise complex presentations. The training to treat people with complex presentations is minimal or left to their own initiative in professional development after completion of their studies.
Clients report that they were not helped sufficiently and want to see only a clinical psychologist. University curricula show too little clinical content.
Mental Health Services in our rural area are very good at support, management and supervision of psychiatric and mental health problems, but have not been given the same therapeutic training as clinical psychologists. There are very successful and informal co-operations between services in this area, which would discontinue without a higher rebate for clinical psychologists, simply because the unpaid work from private practitioners in the management of these clients would not be affordable anymore.

Every year several of my clients acknowledge that their life would not be the same or would have possibly ended had they not been given the specific one-on-one clinical

support they can access through the Better Access Scheme as it is. Can we afford to put these people at risk or in the situation where they have to access less suitable counselling or have even fewer consultations available? Juggling the needs of clients with complex presentations with 18 sessions per year is difficult enough- ask any practitioner and they will agree.
The suggested changes for Mental Health services will mean in our area that clinical psychologists will not be accessible for 18 sessions anymore. ATAPS will not be able to provide sufficient services for the clients in this area, since most of the contracted psychologist are not specialised in clinical psychology.

Clinical psychology is the only specialisation in psychology that has been trained to perform clinical mental health assessments and diagnosis's. They should be allowed to take clients without GP referrals since they are better trained in psychological assessment and able to diagnose and refer clients to their own practice.

The higher Medicare rebate honours 50% longer study time and more extensive professional development over the last decades for clinical psychologists (PD has been compulsory only for clinical psychologists for many years, not for psychologists).

Because of the higher rebate clinical psychologists are able to bulk bill clients with more severe presentations who are frequently on Centrelink payments as well. This will change if they receive less payment. The people wearing the loss will be clients from the more severe end of the spectrum again. I have bulk billed most of my clients for the fact that they have been unable to pay a full fee upfront and be reimbursed later.

Should you decide to bring the rebate for clinical psychologists down to the rebate that all psychologists receive you will inevitably find that the standards and expertise will decline. (Who wants to go through the trouble of doing 6 years of study with a much higher debt when the earnings don't reflect the difference?)
As a person who migrated to Australia based on my skills I was surprised and concerned that practicing psychologists (non clinical) may not even have been trained in psychopathology and may have only very few therapeutic skills.
Who, if not the clinical psychologists will be able to work with clients with multiple issues, severe trauma, sexual abuse and other presentations?

From my own practice I would recommend to make 6 years of study including clinical case work compulsory for all people who wish to work with mentally ill people in a therapeutic way, like it is in most other countries. Rather than dragging the standard down to less qualification we should aim to make treatments the best possible.

Also I recommend that people with more complex presentations or more than one diagnosis should have access to up to 30 sessions per year to really make a change in their lives and have access to qualified support on a weekly to fortnightly basis. (Germany allows for up to 60 sessions per client and more after a review.)
They should also only be referred to clinical psychologists, who have sufficient training in dealing with such presentations. For the remaining clients (the majority) and psychologists the sessions can be capped at 12 (+6 in exceptional circumstances)

per year. Assessment can be performed by GPs and clinical psychologists to determine the severity of the mental health disorder.

It is my experience from my own practice and from other clinical psychologists that the management of clients with complex issues often requires time which is not accounted for: sessions take up to 2 hours, phone consultations in between sessions, additional readings or supervision or peer consultation. There may be involvement of or letters to other services such as GP's, mental health, Centrelink, job agencies, housing agencies. Sometimes care needs to be co-ordinated with other services. Clinical psychologists tend to see more of such clients and are better trained and more experienced in networking and involving other services for their clients than many other professionals including general psychologists. This should be reflected in a higher pay and specific pay for some of the work outside of sessions.

I also recommend that people on low income or on Centrelink payments should be able to pay just the gap fee during a consultation. The current system allows psychologists to bill Medicare directly only if they bulk bill. This puts unnecessary stress on both, psychologists and clients. It should be possible to bill directly from Medicare and allow clients to pay the gap fee only during a consultation. Clients who are on Centrelink struggle to pay $130.00 or 150.00 per session upfront. In rural areas it can take weeks before they get the Medicare rebate reimbursed.

I sincerely hope that you consider these suggestions as well as the input from other practitioners and scientists from the field. Better Access to Mental Health has been an immensely successful initiative which should be built on in the future, not reduced. If you do the numbers (sessions provided and outcomes achieved/ per yearly expense) you will find that there is no way to provide services of comparable efficiency and quality for the same amount of money. I have worked in several government and non government positions and I am very much aware of the performance/ cost ratio in different case scenarios. Please take the feedback and data from both clients and psychologists to form an independent and practice based opinion before you apply budget cuts that will lead to more costs, less efficiency and mental health issues that could have been prevented by keeping this successful initiative in place and extending it to provide even better services. Please support the specialisation in clinical psychology by keeping a two tier system.

Thank you for your interest and please contact me should you wish to discuss this letter.

Kind regards,

Claudia Michels