26th July 2011

Attention: Senator Boyce
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600
Australia

Re: Commonwealth Funding and Administration of Mental Health Services

I write in relation to the Senate Community Affairs Reference Committee inquiry into Commonwealth Funding and Administration of Mental Health Services.

I am a clinical psychologist in public and previously private practice on the Northside of Brisbane. My public practice is within specialist aged psychiatry service and previously my private practice involved seeing a range of complex adult and older adult patients with mixed diagnoses, but included many with severe disorders. I have a Doctorate in Clinical Psychology and have dedicated my career to assisting some of the most vulnerable members of our community, particularly older people with long-standing and first presentation mental illness, in particular those whose functioning (cognitive, physical, social, emotional, and behavioural) is significantly impaired by their mental illness.

The Government states that they will rationalise allied health treatment sessions and reduce the number of allied mental health treatment services for patients with mild or moderate mental illness under the Medicare Benefits Schedule.

The term rationalisation does not do justice to their plan. They intend on reducing Medicare psychology consultations from 18 (not 12) to 10. There are certainly patients I see who do not need 10 sessions, and I will not see them longer than needed. As a clinical psychologist with a busy schedule, it makes no sense sitting in a room with a well patient for an hour, and of course we don't. We use the number of sessions we need to achieve an acceptable outcome for the patient in collaboration with their GP. The demand for clinical psychologists (and I specifically state "clinical" due to the training and development required in order to be competent to practice with severe specialised populations) with expertise in older adult care is stagnant as the older population grows. Demand for private psychology services is expected to rise as large cohorts of middle-aged individuals, who are likely to be more accepting of psychological intervention than the current generation of older people, move into old age. Researchers estimate that almost two-thirds of older adults with a mental disorder do not receive needed services. Research suggests that a majority of older adults would want to be treated should they become depressed. When given a choice for the treatment of depression, older adults often prefer psychological services to medication. Older adults report feeling comfortable receiving psychological interventions from suitably qualified mental health professionals. However, research indicates that many health professionals are not adequately trained to assess and treat psychological problems and comorbidities in this specialist field.

Studies indicate that 50-70% of all primary care medical visits are related to psychological factors such as severe anxiety, depression, and stress. Recognition and treatment of mental health conditions in the medically ill may be especially difficult. As older adults typically have one or more chronic medical conditions, clinical psychologists' skills are particularly useful in diagnosis and treatment. Clinical psychologists have many skills that can be of benefit to and significantly increase the well-being of older adults. They are often called upon to evaluate and/or assist older adults with regard to serious illness, disability, stress, or crisis. Older adults may manifest their developmental struggles and health-related problems in distinctive ways, challenging clinical psychologists to recognise and characterise these issues accurately and sensitively. In addition, other special clinical problems arise uniquely in old age, and may require additional diagnostic skills or intervention methods that can be applied, with appropriate adaptations, to the particular circumstances of older adults.

Clinical work with older adults may involve a complex interplay of factors, including developmental issues specific to late life, cohort (generational) perspectives and preferences, comorbid physical illness, the effects of taking multiple medications, cognitive or sensory impairments, and history of medical or mental disorders. This complex interplay makes the field highly challenging and calls for specialised clinicians to apply psychological knowledge and methods skilfully. Therefore the contribution of clinical psychologists in the area of ageing continues to grow dramatically, and with this increased involvement in working with an older population comes a responsibility to recognise that such work must conform to a high standard of practice. Moreover, given the likelihood that most clinical psychologists in the ageing field will deal with patients, family members, and caregivers of diverse ages, a rounded postgraduate education encompasses specific training (which is not afforded to 'generalist' psychologists) with a lifespan-developmental perspective that provides knowledge of a range of age groups, including older adults.

It is well known that the figures for people with dementia is expected to increase x 4 by 2050, with 2.8% of the population being diagnosed, equalling 175,000 new cases per year. As a result we already experience a significant number of clients in geropsychiatric inpatient and outpatient settings that are cognitively impaired, whereby clinical psychologists are often called upon to perform cognitive testing. Five of the major reasons for such specialised assessment are: 1) To evaluate cognitive ability; 2) to detect and monitor cognitive changes; 3) to evaluate dementia; 4) to assist with the differential diagnosis of dementia versus depression; 5) to help determine decision making capacity. Although strenuous efforts are exerted to identify the physiological causes of dementia, there are still no conclusive biological markers short of autopsy for the most common forms of dementia, including Alzheimer's disease. Neuropsychological evaluation and cognitive testing remain the most effective differential diagnostic methods in discriminating pathophysiological dementia from age-related cognitive decline, cognitive difficulties that are depression-related, and other related disorders. Even after reliable biological markers have been discovered, neuropsychological evaluation and cognitive testing will still be necessary to determine the onset of dementia, the functional expression of the disease process, the rate of decline, the functional capacities of the individual, and hopefully, response to therapies.

I can't imagine GPs being restricted to only 10 weeks of antidepressant medication per patient per year; this makes no sense. Mental illnesses take many years to develop, often beginning with suboptimal childhood environments, and they take longer than 10 x 1 hour sessions to resolve. The independent review of Better Access lauded this program as one of the most effective, and efficient health interventions ever. I and many of my patients are grateful to this brilliant initiative of the previous government. I predict that this short-sighted attempt to save money will be more wasteful in the long-term, since the more severe disorders will be partially treated and patients will do the most natural thing without ongoing support, that of slipping back into past patterns of behaviour leading to relapse. Relapse itself is a very serious and complex problem, and may lead to worsening illness and increased suicide risk as the patient experiences failure and loss of self-esteem and confidence.

The Gillard Government suggest that patients with moderate to severe mental illness are neglected and should be moved to ATAPS. However there are problems with their assumptions. My experience, and the Independent review of Better Access and the Survey by The Australian Psychological Society confirm, that the vast majority of patients seen by psychologists under Better Access are in the severe range of mental illness at first consultation. The Review also showed that psychologists were successfully treating patients very efficiently by world standards. We are already treating severe patients and this is what I am trained to do. People with mild mental illness don't tend to present for help from a psychologist anyway until the illness becomes severe. By moving an economical system with little red tape, psychologist bulk-bills or patient claims rebate, to ATAPS the Government is adding a layer of administration that will drain a large proportion of funding away from primary mental health care. Working within the patient-psychologist-GP relationship also helps to reduce community and self-stigma and normalises the provision of mental health care within the normal health service. Referring a patient through ATAPS risks increasing stigma, since they need a special program and referral, rather than the normal process of GP referal that occurs for every other significant illness. This is

discriminatory and harmful and will discourage patients seeking the care they need, and may lead to a return to the high prevalance of untreated mental illness in our community, with its consequent morbidity, financial and social burden. In our business, we never know how many lives we save, but we do know how many we don't.

ATAPS will likely lead to reduced expertise in care for those with severe mental illness, the reverse of the Government's intention. As a clinical psychologist with the highest qualification for this work, I do not contract to ATAPS because of the low level of payment and the added complexity. My junior, less qualified and less experienced colleagues contract to ATAPS because they need the work early in their careers. The Government's plan will lead to an increase in the least qualified psychologists contracting to ATAPS at the lowest possible rate and seeing the most severe patients, while the highly qualified clinical psychologists will maintain their practices seeing more of the mildly mentally ill. This is unnecessary waste for a health system under burden. This ATAPS proposition will replicate the most unsatisfactory aspect of public mental health, that of being staffed by the most junior and least qualified staff. It should be noted that psychologists under Better Access have taken a substantial burden off the public mental health services, and I regularly accept these patients.

I am not opposed to all of this package. I do believe that junior psychologists and those without post-graduate training in clinical psychology would be better supported under an ATAPS framework while seeing less severe patients but without a cap on sessions. However, as mental health specialists with 6 or 7 years of university training (compared to 4 years for registered psychologists) and years of experience in mental health working closely with psychiatrists and multidisciplinary teams, clinical psychologists should be encouraged to continue seeing the more severe patients as they have been doing quite successfully and efficiently, and without the encumbrance and inefficiency of ATAPS.

Another proposition of the Government is to eliminate the two tier system of rebates to registered psychologists (tier 1) and clinical psychologists (tier 2). Given the Government's desire to rationalise, this seems like reduced spending, we expect that they will seek to remove tier 2. Thus, patients of clinical psychologists, with advanced training and specialisation in mental illness, will receive the same rebate as patients of registered psychologists without this specialist training, equalising the compensation rates for these two categories. It should be noted that Australia is the only Western nation that allows a psychologist to register and practice on mentally ill people with only 4 year of university training; training that does not include any patient contact. This will discourage existing clinical psychologists from practising within the Medicare system and encourage movement into other areas of private health (e.g., Employee Assistance Programs), and discourage those undertaking the substantial burden of clinical post-graduate training, since there would be no financial incentive and significant disincentive. I have already heard clinical psychology students discussing the option of dropping-out of post graduate clinical training if the rebate differential is removed. Rather than increasing the training standards of the psychology workforce to international standards, it will do the opposite and in the end be reflected in patient care.

Thank you for your consideration and I hope that the senate inquiry reveals the true issues with the proposed changes to funding and administration of Mental Health Services.

Yours sincerely