Launceston Therapy Clinic

Launceston

8th July 2011

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

Dear Senate Standing Committee on Community Affairs

RE: Commonwealth Funding and Administration of Mental Health Services

Submission

Please accept my submission to the Community Affairs Reference Committee which considers aspects from the terms of reference into the Commonwealth Funding and Administration of Mental Health Services.

(b) changes to the Better Access Initiative, including*:*

(i) the rationalisation of general practitioner (GP) mental health services,

(ii) the rationalisation of allied health treatment sessions,

(iii) the impact of changes to the Medicare rebates and the two-tiered rebate structure for clinical assessment and preparation of a care plan by GPs

Certainly some rationalisation is necessary for the Better Access Initiative. For example, the rationalisation of rebates for General Practitioners, who refer and produce a mental health care plan could be reconsidered and reduced. Essentially, it could be argued that General Practitioners (GP) are not sufficiently qualified to diagnose and develop treatment plans for individuals with potentially serious mental illnesses. Only psychiatrists and clinical psychologists are sufficiently qualified to undertake such work. Moreover, it is

likely that GPs will continue to refer to psychiatrists and clinical psychologists because they find the service invaluable and they are not confident to deal with such patients.

(iv) 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;

Practitioners such as social workers and psychologists possibly could address patient's needs within 10 sessions, as they would be undertaking less complex presentations. Having said that if they were not producing outcomes perhaps the client should have been referred to a psychiatrist or clinical psychologist in the first instance.

(d) services available for people with severe mental illness and the coordination of those services;

I would remain hopeful that the existing provisions to service severe mental illness remains constant or extended. Psychiatric medicine primarily considers a pharmaceutical approach, whilst clinical psychologists employ evidence based therapy. The incongruence between the psychiatrist number of session per calendar year to that of the clinical psychologists remains puzzling as the primary course of treatment (e.g., therapy) can take longer than 18 sessions. Moreover, the general public in my opinion should be able to exercise freedom of choice and opt for the treatment or combination of interventions that best suits them.

In fairness I remain impressed with the amount of successful outcomes that have occurred with collaboration between psychiatrists, GPs, psychiatric nurses and clinical psychologists in the rural areas that I undertake practice. I was sceptical if the Medicare system would be successful with clients because a collaborative and integrated approach is helpful during treatment, particularly with the severely mentally ill. However, professionals are working together across private practice with the GPs as a focal point and achieving outcomes. This has been particularly relevant in a rural community with a paucity of services. It is not clear if ATAPS could produce that same success.

(e) mental health workforce issues, including:

(i) the two-tiered Medicare rebate system for psychologists,
(ii) workforce qualifications and training of psychologists

I believe the two-tiered rebate system for psychologists is appropriate because it reflects rewarding skill level. To illustrate the point , there is no suggestion that an individual that leaves secondary school in year-ten has the same abilities as an individual who leaves secondary school in year-twelve. There remain clear qualitative and quantitative differences in the level of training, which is reflected in the current two-tier system. I am certain that there are some psychologists who perform better than clinical psychologists, just as there are people who leave secondary school in year ten who become more successful that individual who fully completed their education. However, on balance the more extensively trained individuals will have a greater potential capacity.

Following on, clinical psychologists are required to undertake greater levels of ongoing professional development than other disciplines including social workers and psychologists. Certain public sector services will not consider employing psychologists unless they are clinically qualified.

Moreover, the two-tiered approach encourages a more skilled workforce which is entirely consistent with international standards. In the UK and USA psychologists are becoming <u>more</u> highly trained – not less. Subsequently the profession needs to remain in step with international standards rather than reinforce or support lower standards of training.

Clinical psychology is one of the few caring profession which is highly regulated, including ongoing monitoring around fitness to practice. Unless professionals are highly skilled and and regulated, such professions should not be permitted to work with the severely mentally ill. This does not happen with clinical psychology or psychiatry and should not be entertained for other professions.

Please consider the rational and evidence as the basis for decision making rather than a majority viewpoint or politically correct positions.

If you have any further queries please telephone 6331 4664 or 0438 645777.

Yours sincerely,

William H. Doudle

Clinical & Forensic Psychologist