COMMONWEALTH OF AUSTRALIA

Proof Committee Hansard

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Commonwealth funding and administration of mental health services

(Public)

FRIDAY, 19 AUGUST 2011

MELBOURNE

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SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Friday, 19 August 2011

Senators in attendance: Senators Adams, Carol Brown, Fierravanti-Wells, Moore and Siewert.

Terms of reference for the inquiry:

To inquire into and report on:

The Government's funding and administration of mental health services in Australia, with particular reference to:

(a) the Government's 2011-12 Budget changes relating to mental health;

(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, and

  (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;

(c) the impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program;

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

(e) mental health workforce issues, including:

  (i) the two-tiered Medicare rebate system for psychologists,

  (ii) workforce qualifications and training of psychologists, and

  (iii) workforce shortages;

(f) the adequacy of mental health funding and services for disadvantaged groups, including:

  (i) culturally and linguistically diverse communities,

  (ii) Indigenous communities, and

  (iii) people with disabilities;

(g) the delivery of a national mental health commission; and

(h) the impact of online services for people with a mental illness, with particular regard to those living in rural and remote locations and other hard to reach groups; and

(j) any other related matter.

WITNESSES

JACKSON, Professor Claire, President, Royal Australian College of General Practitioners

MARLES, Dr Elizabeth, Vice President, Royal Australian College of General Practitioners

RAWLIN, Associate Professor Morton, Chair, Victoria Faculty, Royal Australian College of General Practitioners

Committee met at 09:04

CHAIR (Senator Siewert): I declare open this public hearing and welcome everyone who is present today. The Senate Community Affairs References Committee is inquiring into the funding and administration of mental health services. Today is the committee's first public hearing for this inquiry. The committee reminds witnesses that evidence should address the terms of reference of the committee and that misleading the committee may constitute a contempt. It asks that witnesses avoid making adverse comments about other parties and warns that such reflections may prompt the committee to suspend proceedings. The committee may decide to take evidence in camera at any stage and witnesses may also ask that evidence be taken in camera. I want to point out that, once we go in camera, there are certain processes that we follow then as well.

I would like to welcome our first witnesses, Professor Claire Jackson, Dr Elizabeth Marles and Associate Professor Morton Rawlin from the Royal Australian College of General Practitioners. Information on parliamentary privilege and the protection of witness and evidence has been provided to you. Should you wish to see a copy of the information again, please let us know. The committee has before it your submission, which is numbered 172. I now invite you to make an opening statement, at the conclusion of which—I am sure that you know the process—we will ask you some questions.

Prof. Jackson: Thank you very much. Firstly, on behalf of 27,000 Australian GPs, I would like to thank you for providing us with this opportunity to appear before the committee and to provide our input to this critical inquiry. The college is gravely concerned regarding the proposed cuts to the Better Access program and their subsequent impact on mental health care delivery for every patient group, demographic and geography throughout Australia. The peak national general practice bodies, including our own college, the Australian Medical Association, the Australian General Practice Network, the Australian College of Rural and Remote Medicine, the General Practice Registrars Australia and the Rural Doctors Association of Australia have been united in our concerns regarding this retrograde policy initiative.

General practitioners deliver more than 120 million patient services throughout our country every year, of which 70 per cent involve chronic disease management, including mental health. In fact, now one out of every five patients attending a general practice has a mental health problem. The cuts to the Better Access program announced in the recent federal budget will jeopardise the mental health care of an estimated one million patients per annum, risking the current high patient access levels, quality of patient care, excellent clinical outcomes and our mental health workforce capacity.

General practice is the linchpin for high quality mental health care delivery in every community and in every state and territory throughout Australia. General practice provides whole patient, coordinated, ongoing health care for people with mental health conditions as diverse as depression, social phobia, bereavement, post-natal depression, anxiety disorder, sleep disturbance and bipolar. We have a heavy accentuation on prevention and early intervention within our population. There are 12,000 Australian general practitioners who currently hold fellowship of our college. The majority of our members have demonstrated significant skills in mental health care across the full gamut of care to achieve this qualification.

In addition, a further 17,000 general practitioners have further demonstrated their commitment to high quality mental health care through additional General Practice Mental Health Standards Collaboration training activities as part of the Better Access program. Our general practitioners have borne in full the costs and after hours time commitment to complete this to provide their patients with access to higher patient rebates for the important mental health treatment that they require. The budget cuts have been formulated despite the proven benefit of the Better Access program, including improved overall treatment rates for patients with mental health disorders from one-third of Australians to a half of Australians in 2009 and improved mental health outcomes. The proposed budget cuts would decimate the delivery of mental health care in Australia and ultimately make the Better Access program unfeasible, despite its proven benefit and clinical outcomes. The Bettering the Evaluation and Care of

Health, or BEACH data, as it is known, has been used inappropriately and repeatedly to justify the proposed cuts to our patients rebates, only taking into consideration the face-to-face clinical time spent diagnosing mental health issues and not including the additional non-clinical time spent preparing mental health plans and coordinating patient care outside that clinical consultation. A recent national survey showed that general practitioners are spending on average 17 extra minutes preparing these plans, alongside the 28 minutes of clinical time shown in the BEACH data. This means that general practitioners are spending on average 45 minutes preparing the planning.

The planned cuts will particularly affect the delivery of services to our most vulnerable patient groups, including general practitioners, such as Liz, working in Aboriginal medical services, refugee health, adolescent mental health and headspace clinics. They all rely on general practitioners using the higher patient rebates through Better Access to deliver accessible mental health care for their communities. Another significant concern regarding the recently announced cuts is that patient rebates for mental health care will now be lower than patient rebates for physical health care, suggesting that mental health care is not as important as physical health care. This is a complete anathema to our members and completely unacceptable. General practice plays a critical role in the delivery of early intervention and preventive mental health services, as well as holistic, whole-of-patient, care across Australia. As such, we must be supported to ensure ongoing high quality access to mental health services in every town and community in Australia. The Better Access program is a crucial part of this.

We would also like to note that we were neither consulted nor even properly advised of the proposed cuts prior to the budget. It is also of concern that there has been no willingness by the government to engage and work with our profession regarding the significant concern raised after the cuts were announced in May. Our college and United General Practice Australia recommend an immediate suspension of the proposed cuts to the Better Access program and call on the government to conduct a comprehensive review, including proper consultation with the profession, consumer groups and all other stakeholders to identify a revised approach that does not reduce access to high quality mental health care support for all Australians and does not imperil a successful and critically important program for Australia's most vulnerable citizens. Thank you very much.

Senator FIERRAVANTI-WELLS: Can I start by picking up on the consultation part, Professor. Were you aware of the minister's little kitchen cabinet of the mental health expert working group? Perhaps at the outset, are you aware of the Department of Health and Ageing submission? Have you had the opportunity to look at that?

Prof. Jackson: I have not read that in detail.

Senator FIERRAVANTI-WELLS: Just picking up on the consultation point: the first you heard about it was, effectively, on budget night.

Prof. Jackson: We were called to a meeting with both ministers, Minister Roxon and Minister Butler, several days before the budget to inform three of the general practice groups that they were 'going out on a branch' around mental health and there was going to be a significant expansion of mental health programs in Australia. Our assumption was that general practice would be involved in that. I then received a phone call half an hour before the budget to say that approximately $400 million in general practice rebates would be going as part of the budget mental health cuts. We have tried repeatedly to meet with the ministers and their officers to raise the misinterpretation of the BEACH data that we believe might have underlined their decision and also to implore them to work with the profession around improving the package on offer—but to no avail.

Senator FIERRAVANTI-WELLS: In fact, there has been quite a bit of criticism undertaken of the Better Access program. It appears to have been in two stages. They had the Better Access evaluation that they did, and then this little working group appears to have made certain decisions. We do not know whether they were based on other priorities or this assessment. That is not clear from the evidence before us. One of the criticisms at the time was that, in a program that cost $1.45 billion and had over 11 million sessions, there were only 1,300 or so consumers that were actually consulted. Is that part of your criticism?

Prof. Jackson: They were small numbers; however, we believe that the evaluation done on the Better Access program was probably one of the very few that we have ever seen that attempted to look at clinical outcomes. So despite the small numbers—and we are talking about mental health care and we have had a lot of patients who were concerned but embarrassed to speak up around indentifying mental health issues—we found that the clinical outcomes demonstrated through the evaluation were highly significant. In fact, it is rare for a Commonwealth program to look outside the impact evaluation to real clinical benefits.

Senator FIERRAVANTI-WELLS: Which is why it surprises you even more that they have gone ahead and done what they have done.

Prof. Jackson: What surprises us the most is that they have done a very fulsome evaluation of the program, by Commonwealth standards, they have demonstrated enormous impact and enormous benefit for the Australian community and now they have carved into that program to such a significant amount.

Senator FIERRAVANTI-WELLS: The AMA has done this survey and it seems to be fairly comprehensive. How many people were actually consulted?

Prof. Jackson: Nearly 1,000 GPs participated in that. It was a national survey.

Senator FIERRAVANTI-WELLS: The point that you make there is that the non-clinical time is vital in terms of consideration and that clearly was not taken into account when they revised the levels. You mentioned the one million people right across the spectrum of ages et cetera. Are you able to provide a breakdown of those one million people?

Prof. Jackson: We have been looking at the one in five patient attendances that are around a mental health issue. That has been well documented. The other point we would like to raise is that general practice plays a very significant role in prevention and early detection. When we see a new mum we are looking for postnatal depression in its earliest presentation. When we see a child with school phobia we are looking at issues around early prevention and keeping that child in school, keeping that person in the workplace and keeping that person in an effective relationship. We have a very pervasive impact across the full gamut of health care in mental health care.

One of the reasons the plan was first brought in five years ago was to allow us to combine that clinical contact with the patient with the telephoning and the non-clinical time to ring schools, to ring workplaces, to ring carers and to be able to really put together a comprehensive intervention for the patient—to keep them well. That is the most disappointing thing: we now are not going to have the opportunity to have that impact which has, we believe, seeded the Better Access program for its success.

Senator FIERRAVANTI-WELLS: Is it fair to say that the investment in a program like Better Access has very much tapped into a vastly unmet need in the community?

Prof. Jackson: Yes. Liz, do you want to talk about that particularly from your perspective?

Dr Marles: Yes. The BEACH data last year showed that around 18 per cent of patients who attend general practice formally have a diagnosis of depression or anxiety. Then there is a further two per cent that may have a diagnosis of bipolar disease or schizophrenia. So it is a very high number of patients presenting who have mental health issues. This program has allowed us to spend the time with those patients, to go through what their issues are, to invest in that relationship and to determine an appropriate treatment plan. I think that is why it has been taken up so much. If you look at the amount of money that has actually been spent on it compared with the amount of mental illness that is out there in the community, it is still probably underfunded in its current form and it will be even more so if these cuts go ahead.

Senator FIERRAVANTI-WELLS: What effect is shifting from Better Access to ATAPS going to have on your profession?

Dr Marles: These item numbers are for the general practice input. That is still required for ATAPS. If I refer a patient to ATAPS, as I did last week—and I work in an Aboriginal medical service—I am trying to access services where they are not going to be out of pocket, which is what ATAPS does. I have to be registered with the division myself. That takes time. It requires a meeting with someone from the division. I then have to get a reference number for my patient and I have to determine whether the psychologist I want to send them to also has a reference number. I have to conduct a specific tool that they want—the DASS21 tool—to assess their patient. We then have to complete all the ATAPS forms alongside our mental health plan form, which we do for Better Access anyway. It is an enormous amount of paperwork and the rebate is not there; it is basically the same. I think the demands on GPs to access ATAPS will be higher because of the fact that there is no gap there, but the rebate time that is given to GPs for the work that they put in—which is huge—is actually going to be diminished. From a general practice point of view, it becomes a really hard slog. These patients, I have to tell you, are usually really quite distressed, sometimes they are suicidal, they are often in the midst of a relationship breakdown, they may have lost work, they are sleep deprived, they are really struggling at a personal level and they are not easy consultations.

Senator FIERRAVANTI-WELLS: On page 9 you make comments about disadvantaged groups. Can you elaborate on that. You make quite strident comments there about diverting funding from universally accessible mental health care providers to programs based on limited international evidence. Can you tell us a little bit more.

Dr Marles: I can give you some examples in Aboriginal medical services, refugee health and some rural practices where these rebates have allowed us to create a business case to employ a psychologist. At the medical

service that I work at in Redfern, we have, since the introduction of the Better Access scheme, employed our own psychologist who we talk to face to face on a regular basis. That actually improves our communication around the particular patient. But it is the funding through this scheme, both in terms of the general practice time and also the number of sessions that are available to the psychologist, that has allowed that business case to go forward. The patients are really struggling at a personal level and so there will often be times when they do not turn up. The fact that you need to fund the time for the psychologist but sometimes those patients may not appear has to be built into the business case. Particularly the really vulnerable patients may have another crisis, such as transport issues. But that does not mean that we should not be trying to help them and that does not mean that we should not be trying to give them access to a psychologist.

Prof. Jackson: The other group we are particularly worried about is rural remote communities. The general practice is it in those areas. In Queensland and Victoria we have had unprecedented natural disasters. Our GPs are telling us that they are increasingly using the planning items to support people in early intervention preventative issues. In rural remote areas they are not going to have the capacity to do that if these budget cuts go ahead.

Senator FIERRAVANTI-WELLS: I was in Emerald recently and there are two GPs there. That was precisely brought to me in very graphic evidence. I have one last question in relation to those one million patients, using the figure that you used. In an area where we are seeing increasingly growing need we are now effectively putting at risk one million people. That is it in a nutshell, isn't it?

Prof. Jackson: From our point of view we see the whole family, so mental illness in a child affects the parents and brothers and sisters. Mental illness in a parent affects the child, so from a family point of view the ripple effect is extraordinary. Again, the opportunity for early intervention is just critical to keeping people in their lifestyles, in their workplace and in their relationships.

Senator MOORE: I will start with the same question that Senator Fierravanti-Wells was asking. I have marked the paragraph on page 9, that talked about further diverting funds from universally accessible mental health to funding based on limited international evidence. I do not think you actually answered the question. That is a very straight statement saying that you have got universal access, limited international evidence, limited patient groups and limited reach. What do you mean by that?

Prof. Jackson: When we met the ministers they suggested it was very important to take the funding that had been there previously to support mental health care for all Australians through better access, and to place it in two particular additional programs.

Senator MOORE: Was this the meeting before the budget or a meeting after the budget?

Prof. Jackson: No, this was after.

Senator MOORE: I am going to ask later about the series of meetings and consultation. It is very clear—I need to get it clear in my mind—about when what was said to whom.

Prof. Jackson: All of this took place afterwards. The two programs that the minister indicated were to receive the funding that he needed to find were headspace, which, as we said in our submission, is largely staffed by GPs using the very items that are going to be reduced, and also early psychosis intervention, where there is conflicting international evidence about the long-term benefits. That is all that that responded to. Also, if I could just add around the ATAPS issue, there was a suggestion that ATAPS, which has been completely exhausted in most divisions in Australia, will receive additional funding, but that will not kick in for 12 months. These cuts will happen very, very soon.

Senator MOORE: The schedule of the post funding is clearly put out into which year, so the ATAPS money does come in the third and fourth year.

Prof. Jackson: We have a big hiatus that is critically worrying.

Senator MOORE: I am interested in the knowledge of the reviews that were done, which, as the minister said, are the basis for some of the changes, and, it was revealed, better access and the BEACH data. Did you have full access to those reviews beforehand?

Prof. Jackson: We did not realise there was going to an issue around either of the programs. When the minister started quoting BEACH data and all the GPs realised he was inappropriately interpreting that data, we contacted the office immediately and said, 'That is clinical-only time. It is not a planning assessment.' That seems to be a message that is impossible to get through, but we felt it was really important for the Senate inquiry to understand the two very different components and the inappropriate mathematics involved in looking at the program initially.

Senator MOORE: So your organisation and individual GPs contacted the minister's office as soon as the BEACH data was out, to talk about it.

Prof. Jackson: The BEACH data has been out for some time.

Senator MOORE: Many months.

Prof. Jackson: But no-one has really looked at it because we knew that the clinical time was about 30 minutes and then we knew that people were spending significant time on the phone calls, putting the record together, doing the referral—all the administrative things that the planning was designed for originally. We did not think that it was going to be a problem. It was that the minister was looking at the data without consultation with our profession to interpret it appropriately.

Senator MOORE: And that has never been discussed before, because the BEACH data is not new.

Prof. Jackson: It has never been misinterpreted before.

Prof. Rawlin: It is true to say that from a clinician's point of view we know what the BEACH data means. We know that the BEACH data is collected on our consultations and we look at the consultations, but we never include in that the parts of the consultation that do not occur with the patient in front of you, which is quite common.

CHAIR: Sorry, why not?

Prof. Rawlin: Basically because that is not what the BEACH data has asked us to do. They specifically ask for the clinical component of the patient interaction that you have face-to-face.

Dr Marles: If I can just elaborate, I participated in the BEACH study this year and it just asked you to record the time that you start the consultation and the time you finish the consultation. It is purely recording consultation time, and most GPs will quarantine a couple of hours in the day where they go through pathology, ring other providers and do all the associated work with those consultations. That is not included in that data.

Senator MOORE: But that is for all consultations.

Dr Marles: It is for all.

Senator MOORE: And I think that is important. Can I clarify that BEACH data is about all interaction between the doctor and the patient that goes back and feeds into the Medicare process.

Dr Marles: No, it is not.

Prof. Rawlin: No.

Prof. Jackson: The BEACH data is a completely voluntary initiative that GPs participate in. It collects 100,000 consultations. It is our main database for looking at what is happening in general practice. The director is very distressed at the way the data has been interpreted and used because it is something that we all contribute to so that we can understand what happens in general practice. It is not linked with Medicare Australia. It in no way reflects our billing time. It is purely looking at what our clinical activity is in any year and how it varies. So the figures of the proportion of chronic disease management consultations we now do come from our BEACH data. It is a really valuable resource. If we lose GP commitment to participating in that it would be a terrible thing.

Senator MOORE: Are you finished? Good, maybe I could go on with my question. BEACH data is not peculiar to the mental health process—

Dr Marles: No, it is for everything.

Senator MOORE: BEACH data is about all clinical interactions with patients. The kinds of things you have been telling us about would be appropriate to any interaction with patients. The BEACH data has been around. We have talked a lot about how it operates. We value the commitment of the GPs to being engaged with that because I think if you make it mandatory you will lose that interaction. The BEACH data has been around a lot. The mental health plan item was there for the discussion. The discussion with the patient was to develop a mental health plan which was going to go back to other services. Inevitably that was going to engage a lot of action—that was the whole idea of bringing it in. Can I find out why the whole experience was not discussed earlier? Why does this take more time than for someone who has a severe oncology issue, with all the different interactions with family and other practitioners, such as pathologists, that they have to take? All of this is not covered in the BEACH data. Why is the BEACH data in the medical plan for mental health so much different to every other calculation of BEACH data?

Dr Marles: When we do the BEACH data, at the bottom of each consultation page we list what item numbers we bill. So there is an item number for a mental health plan and that is how this is being drawn out. If we had a complicated oncology patient we might undertake a GP management plan for that patient. That data is also

extractable from BEACH—it does not specify that it is about cancer, heart disease or any other chronic illness, but it is there. It just relates to the way in which Medicare has asked us to bill patients.

Prof. Jackson: The BEACH data has been around for a long time. We were just talking before about how the nature of general practice has changed in such an enormous manner over the last five years, with an ageing population and with increasing complexity. When I started in general practice it was all about a clinical one to one. I rarely rang around or did stuff with other people. I did not work in a big team. Now that is the way general practice works, to the betterment of patient outcomes. So the planning items have crept into our MBS to recognise the time involved in that, but BEACH is on a historical arrangement. I think that is a very good point: maybe we should be looking at how we collect data and move from what the original aims of BEACH were 15 years. Maybe we should look at the clinical interaction and at a much broader collection of data which represents the service to deliver a clinical outcome, which is what we are all focused on.

Prof. Rawlin: Certainly we have been discussing the issue that there is extra time, outside of the face to face, with government and the department. It is brought up at, say, the ATAPS committee, which I have sat on previously. Those who are involved in that do understand that there is a lot more to it than the face to face, which is absolutely critical, but unless you do the other stuff as well the patient does not get the appropriate care. It is about enlisting the team to be part of the process.

Senator MOORE: And that has not been clearly—

Prof. Rawlin: It has not been taken up, no.

Senator MOORE: It has not been explained?

Prof. Rawlin: No.

Senator MOORE: So that has been a gap in the way people have been looking at this over a period of time?

Prof. Rawlin: From the analysis perspective, yes.

Senator ADAMS: Thank you for your opening presentation. In turning to page 12 of the submission from a number of GPs who have written about their practical issues, Dr Marles I might direct it to you with your rural experience. It is about the increase of funding for ATAPS, and that ATAPS funding is going once the divisions disappear, and it is going to Medicare Locals. There is a comment here by this particular GP saying that they feel that these Medicare Locals are unlikely to serve our rural communities well, particularly because there is no clarity about what they will look like. Have you done any work on what the Medicare Locals are going to do and how they are going to actually get out to these particular areas and probably more into the Indigenous communities?

Dr Marles: I am not a rural GP; I work in Sydney. I do not know whether you would like to take that question, Morton?

Prof. Jackson: I am happy to take it from a national point of view because the college has been very involved with the GP sector and around the move to Medicare Locals. It is very early so our first 15 Medicare Locals were only incorporated on 1 July. It will be a rolling tranche over the next 12 months as the Medicare Locals take shape. They are very different in different parts of the country. To be fair I think there are only one or two rural Medicare Locals that have formed. In Queensland we are going from quite small divisions to really, really large surface areas for the Medicare Locals. There is concern, particularly in rural Queensland, that that will be a distancing of need from quite a local community focus, which is the current divisions, to a much broader, bureaucratic focus. They worry very much that their service delivery capacity will not be recognised the way it is now.

Prof. Rawlin: I agree with Claire. The issue for general practice around Medicare Locals is that we really are still very much in the dark as to exactly what these entities are truly going to end up as. I think that it is a work in progress. The issue, I suppose, for GPs is that we are not sure whether Medicare Locals are going to take over all the functions of the divisions and how effective they will be working with GPs at a local level, and at the moment the evidence is not there. It is an area where we are concerned. We want to work to try and make it happen but we really do not know.

Senator ADAMS: As a national body what plans do you have to make sure that mental health services are accessible to rural and remote people through these Medicare Locals?

Prof. Jackson: We would like the status quo to continue where GPs can work, as Liz said, individually with their patients, with psychologists and with other groups that are freely available and easily available to our patients to get the sort of outstanding outcomes we have had from better access. Moving to Medicare Locals and ATAPS funding a fair way down the track leaves this void where we just really do not know what is going on. As

a national body we are advocating that we stick with what we know is effective. GPs at the moment rebate only or bulk bill 93 per cent of their patients for care planning. That sort of access is critical to retain particularly in rural and more disadvantaged areas where people can get access to a mental health professional.

CHAIR: I was interested in the comment you made that you would like the status quo to remain. I am presuming that your patients are accessing ATAPS at the moment?

Prof. Jackson: Not universally.

CHAIR: All we heard in the past were positive things about ATAPS. Now you are saying that it does not meet people's needs.

Prof. Jackson: We are all in different parts of Australia. In Queensland, particularly in rural and remote areas there are a lot of GPs saying that the ATAPS requirements—because all the divisions have different requirements for ATAPS access—do not meet a significant number of their patients, whereas with the current arrangements if the patient has a mental health need and they work with teams within the practice or close by they can move straight in with the acute mental health crisis and get going. So ATAPS has different rules and regulations across Australia. A lot of divisions spend their ATAPS funding six months into the 12 months and then there is nothing left. Also, as Liz said, often there are bureaucratic issues that have to be gone through to finally access the service. Often in mental health emergencies timing is everything. If you have someone who is suicidal or in acute personal crisis, you want to link them with services quickly. So, from my perspective, nationally those are the three issues that most concern our members about ATAPS.

Dr Marles: I would echo what Claire has just said. We have had occasions on which we have been notified by the division that there was no more funding for ATAPS for the rest of the year because it has all been used. Certainly to ring up to try to refer a patient only to discover that the psychologist that we think is appropriate for that patient is not registered with ATAPS is an issue, because the psychologist is paid directly by the division and so they have to enter into a relationship as well. From the point of view of equity ATAPS is a good program, but it also means that not all patients with a mental illness, who do need to be treated, who do need to stay in their jobs and do need to keep their relationships together, will be eligible for ATAPS consultations.

Prof. Rawlin: One last point is that it is important to realise that the ATAPS program came before the current Better Access and, as such, it was a huge benefit to patients who previously had no access, apart from private mental health services. So it was a marvellous program as a starting point. Now we have moved into the Better Access program, which is much more universal and able to be utilised by a lot more people, and it is time to improve on the processes and ability to use the ATAPS program for the most appropriate people—that is, the underprivileged, who were the original target for that area.

CHAIR: Thank you.

Senator ADAMS: I want to move on to a completely different subject. The committee has received a significant number of submissions from psychologists, regarding the potential changes to the two-tier system currently in place for clinical and general psychologists. Can you provide the committee with a breakdown of the proportion of patients whom GPs referred to clinical psychologists and can you do the same for general psychologists? Have you got any information?

Prof. Jackson: We have no data on that. To pick up on Liz's point, our general practitioners normally like to work in a team with psychologists in order to get to know them and to try to match the patient's need with the psychologist and their background training and skills. From my perspective it is mostly an individual local team arrangement, but we do not have any national data. I do not know whether Liz or Morton has any local data?

Dr Marles: No.

Prof. Rawlin: No, not really.

Senator MOORE: I want to put on record that the government has no potential changes to the two-tier system on record. It has caused immense confusion. There has been a lot of evidence from people suggesting that but it is not in our plan.

Senator CAROL BROWN: I want to ask some questions about the BEACH data. Do you know how many GPs are participating that?

Prof. Jackson: There are 100,000 consultations per year, collected across about a thousand or so practitioners.

Dr Marles: I think it is a thousand GPs who record 100 consecutive consultations each.

Senator CAROL BROWN: Can you give us some more information about the AMA survey that you mention in your submission? Do you know how that was conducted?

Prof. Jackson: Yes. The AMA put the survey together after United General Practice Australia identified universal concerns around this. They undertook on behalf of that collection of general practice organisations to conduct the online survey. We all let our members know that the survey was there and those members who wished to participate we encouraged to do so, and I think nearly a thousand GPs participated over the 10 days that they needed to collect the data to give some sort of extra information about the non-clinical time that BEACH was not collecting.

Senator CAROL BROWN: How many GPs are there across Australia?

Prof. Jackson: We have 27,000 GPs on our vocational register.

Senator CAROL BROWN: You have 27,000 GPs and 1,000 GPs were surveyed, so that is less than five per cent. Thank you.

CHAIR: I have one question—I would have lots, but we are out of time. It relates to your comments, Professor Rawlin, around ATAPS and Better Access. Do I take from your comments that you prefer to see Better Access remain as it is and amendments made to ATAPS? Would that be a correct inference?

Prof. Rawlin: Certainly the Better Access programs rebates need to stay constant. In my opinion improvements can continue to be made in the ATAPS program. Some of that is around letting the appropriate people access to that and making sure that the educative process for providers is there. The overall provision of packages for people with multiple illnesses and so forth, which is in the new ATAPS, certainly will benefit some people, but it is a small percentage of the population.

Prof. Jackson: Certainly our member inputs indicated that they very highly value the flexibility and the immediacy that they have with Better Access. As Morton said, ATAPS was a really good start, but it has fairly strict criteria which often that critically needy person in front of you does not meet.

Dr Marles: I want to make one other comment about ATAPS. The really positive thing about ATAPS is that our patients are not out of pocket when they go and see a psychologist. It is really important that that program stays. As Morton has said, it is there for the people who really cannot afford to pay for a psychologist but need to have one. But there are still other people who need to see a psychologist who can afford to pay a gap payment who may not be eligible for ATAPS.

CHAIR: Thank you very much. We could keep talking for longer, but I have run over time. I think there was a little bit of homework you took on notice.

Prof. Jackson: Yes. The comments about the BEACH and the change in approach are very useful and we will be working on that with BEACH in the longer term.

CHAIR: Thank you very much.

Senator FIERRAVANTI-WELLS: If you could take on notice to look at the departmental submission and if you do have any comments come back to us. That would be very helpful.

CHAIR: It is extra homework, but it would be very much appreciated.

Senator MOORE: The other one that has come out overnight is the Mental Health Council submission. You may be interested in that one as well.

GIESE, Ms Jill, Executive Officer, Australian Psychological Society

HOSIE, Ms Elaine, National Chairperson, Australian Psychological Society College of Counselling Psychologists

LITTLEFIELD, Professor Lyn, Executive Director, Australian Psychological Society

[09:49]

CHAIR: I welcome representatives of the Australian Psychological Society and the Australian Psychological Society College of Counselling Psychologists. I understand information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. I remind all witness that if you want an extra copy or need extra detail then ask the secretariat. I remind all witnesses that evidence should address the terms of reference of the committee and that misleading the committee may constitute a contempt. Witnesses are asked to avoid making adverse comment against other parties and warns that such reflections may prompt the committee to suspend proceedings. As always, the committee can decide to take evidence in camera and at any stage witnesses can ask to go in camera, at which point we go through another whole process. I will only invoke that if there is a request. The committee has your submissions before us. I invite you to make a short statement and then we will ask you some questions.

Prof. Littlefield: The APS welcomes this opportunity to appear before the Senate committee. As the peak body for the profession of psychology in Australia, the APS represents more than 20,000 members. The views presented by us today and in our submissions are those of the elected board, which is the ultimate decision-making and policy-setting body for the society. The board makes decisions in the best interests of the whole APS membership as well as in the best interests of the community that psychologists serve.

The APS understands that this Senate inquiry was primarily established to investigate the 2011 federal budget cuts to the Better Access initiative, the most significant of which was a reduction in the maximum number of sessions of psychological treatment allowed per client per year from 18 to 10. The terms of reference for the inquiry have now broadened, but the APS urges the Senate committee to focus its attention on the federal budget cuts as these are due to come into effect on 1 November this year and will deny effective psychological treatment to an estimated 87,000 people per annum.

Since the government announced the budget cuts, the APS has undertaken a study of the nature and severity of disorders of the consumers who will actually be affected by these cuts. The research conducted on a large sample of 9,900 people who received between 11 and 18 sessions of treatment from psychologists under the Better Access initiative last year shows that these people are overwhelmingly those with severe depression or anxiety disorders. The APS study demonstrates that 84 per cent of these people had a moderate to severe or severe disorder at the commencement of treatment, with 65 per cent having additional complexities such as a second mental health disorder, a personality disorder, a drug abuse problem, an alcohol abuse problem or a family relationship breakdown. The research showed that by the end of psychological treatment only three per cent remained severely affected, while, for 43 per cent of the people, disorders were effectively reduced to either no symptoms or only a mild presentation.

These people would be denied the additional sessions of psychological care required for effective treatment through the Better Access initiative under the 2011 budget funding cuts. The vast majority of these people would also be denied access to public sector mental health services as they have high-prevalence disorders and are not necessarily in need of team based care. The government has stated that people affected by the cuts can be seen under the Access to Allied Psychological Services, or ATAPS, program run through the divisions of general practice, but this is not a viable referral option under current arrangements. There is simply not enough funding in ATAPS to provide services for anything like the 87,000 people per annum.

In addition, ATAPS costs from two to 10 times more per session than Better Access. The government's own evaluation of the Better Access initiative demonstrated that it is a cost-effective way of delivering mental health care. Successful treatment also reduces costs of hospital admissions and allows many consumers to return to work, with the associated productivity benefits.

The resounding evidence from the representative APS study of nearly 10,000 Better Access consumers who needed more than 10 sessions demonstrates that budget cuts to the Better Access initiative are misguided. The APS urges the Senate committee to recommend that these funding cuts are reversed, to enable those many thousands of Australians with serious yet all too common mental health disorders to continue to access the appropriate length of effective and cost-efficient psychological treatment under the highly successful Better Access initiative.

Because there has been controversy about the two-tiered structure, I want to just talk a little about that. I want to talk about what the APS position is on the Medicare rebate structure. Under the current two-tiered rebate structure, the APS board believes that there should be a broadening of the upper tier to include services provided by clinical and other psychologists who possess specialist skills in the treatment of high-prevalence mental health disorders. The board stands by the original proposal it submitted to the government in early 2006 in terms of a broader definition of psychologists who are considered to have the necessary skills to be considered a specialist in providing treatment for high-prevalence mental health disorders and hence to deliver services at the higher fee level under the current structure.

The eligibility criteria to provide services under the upper tier are therefore recommended to include psychologists with specified training to enable specialist competence in psychopathology, including assessment, diagnosis and case formulation, counselling skills, treatment planning and psychological interventions and with specified supervised experience post registration in a mental health setting.

The APS board believes that the two-tiered Medicare structure with a revised format should be maintained because it recognises and values specialist knowledge and skills, as does the MBS in general. The APS considers that psychologists with specialist skills would include those with postgraduate professional master's and doctorate degrees who possess the specified training and supervised experience, as well as those very experienced psychologists with four-year undergraduate degrees who can demonstrate that they meet the specified mental health training and supervised experience criteria.

In the lower tier, there are many other psychologists who do not have specialist qualifications and experience but who are competent to treat consumers with high-prevalence mental disorders and who the Better Access evaluation has shown offer effective treatment for consumers with mental disorders. There is no way the huge public need and demand for psychological services could be met without both these groups being funded under Better Access.

CHAIR: Thank you. Ms Hosie or Ms Giese, do you want to make a statement?

Ms Hosie: The College of Counselling Psychologists supports the APS position on the proposed changes in funding to the Better Access system. We argue for the retention of the 18 sessions for Medicare clients, as outlined in our college submission. I do not want to talk more about that here in the opening statement, but I particularly want to address the two-tiered system, because that has affected very much counselling psychologists and has led to a lot of division and discontent within the profession but particularly for counselling psychologists. I want to address six or seven points that point to that discontent.

The College of Counselling Psychologists supports a two-tiered system which recognises advanced training in treating mental health disorders. The implication that clinical psychologists are the only specialty with advanced training in mental health assessment, diagnosis, case formulation, psychopathology and evidence based treatment is an inaccurate one. Counselling psychologists also undertake advanced training in these areas. They complete a minimum of eight years of training, including a postgraduate degree and two years of supervision post qualification. They complete in their training at least three supervised placements, which are undertaken frequently in the same agencies as clinical psychologists—for example, in headspace, hospital clinics, GP divisions, university counselling services, prison counselling services, Department of Veterans' Affairs, community health services, child protection services and schools.

In addition, counselling psychology provides advanced training in a number of areas implicated in the aetiology of mental health disorders including loss and grief, trauma and assault, relationship difficulties, domestic violence and dysfunctional relationships. The postgraduate training in counselling psychology includes courses in couples, family and group therapy and assists counselling psychologists to detect and respond to mental health disorders in those groups. I have the course guidelines here that support those statements. The current two-tier system means that patients are not getting access to the diversity of clinicians with advanced training and competencies in mental health disorders. Over time, this leads to psychological services for mental health disorders being less diverse and less able to meet the increasingly complex and specialised needs of contemporary Australia.

Additionally, only Australia makes this distinction between clinical and counselling psychologists in terms of primary mental health care. In the USA and the UK, both clinical and counselling psychologists are seen to be equal as front-line mental health providers. In the UK the national health system employs clinical, counselling and health psychologists on exactly the same pay scales—bands 7 to 9. Here in Australia, in a number of universities, both clinical and counselling students actually share the same teaching units. They sit in the same units in assessment, diagnosis and psychopathology, yet under the better access scheme counselling psychologists are only acknowledged as generalists, not as specialists.

In practice, counselling and clinical psychologists work side by side in medical clinics being referred clients with the same high-prevalence disorders such as depression, anxiety and comorbid conditions, yet the clients of clinical psychologists receive a considerably higher rebate than the clients of counselling psychologists. As Professor Claire Jackson said earlier, there is no evidence to support the idea that GPs refer more complex and severely affected cases to clinical psychologists. I am a clinician and I talk to GPs often and they tell me, 'We refer to the psychologists that we know get results.'

Counselling psychologists are trained extensively in evidence based psychological therapies. However, under the better access scheme they are only deemed fit to deliver focused psychological strategies to their Medicare clients. In our opinion this constitutes a restrictive trade practice and a huge ethical dilemma for counselling psychologists, because we are directed by the government to deliver only focused psychological strategies and yet we are trained in advanced psychological services to the mentally unwell. That is an ethical dilemma every day sitting in front of Medicare clients.

In summary, we support a two-tier system and we urge the government to change the top tier of Medicare rebate for psychologists to include all mental health specialist psychologists. The top tier should include all postgraduate trained specialists who have received advanced training in mental health disorders, and this of course would include counselling psychologists.

CHAIR: Ms Giese, did you want to add anything?

Ms Giese: No, I am happy with what has been said.

Senator FIERRAVANTI-WELLS: Professor, at the outset I just want to remind you that the terms of reference that we are here to examine today was a decision of the Senate. It was a motion supported by Senator Siewert of my motion. I do not know where you got your misinformation that it started out as Better Access and is now something else. So, for the record, Professor, I would like to correct your assertion.

CHAIR: It is true it was kicked off by the changes, but the Senate has decided to give us broader terms of reference.

Senator FIERRAVANTI-WELLS: The other thing is, as shadow minister in this area I am just amazed at some of the things that have been relayed to me about the conduct of this inquiry. To some extent it has been very positive, in the sense that we have really seen just how much at war the whole psychological industry is. For the benefit of millions of Australians who need help, I think it is actually quite appalling. It is very clear that you are not on the same page. You say you represent 20,000 members. How many of those members actually agree with what is in your submission, Professor?

Prof. Littlefield: From the many emails we got after stating our position it is clear that many members do agree. The way the society works is that the 20,000 members elect the board and the board is the decision-making body and policy-setting body for the society. This is the board's decision, the board's position.

Senator FIERRAVANTI-WELLS: Can I understand. You have nine colleges.

Prof. Littlefield: Yes.

Senator FIERRAVANTI-WELLS: Your colleges are not all on the same page on this issue?

Prof. Littlefield: I think we are exactly on the same page to do with the Better Access cuts. It is the two-tier structure that differs between colleges.

Senator FIERRAVANTI-WELLS: If I understand correctly, you are the 'peak' group. You have your colleges, who obviously do not share the same view as you in relation to the two-tier system, and then you have two breakaway groups, the Australian Clinical Psychology Association and the Australian Association of Psychologists Inc. Is that the correct picture?

Prof. Littlefield: It is my understanding that the vast majority of the colleges do agree with our position. There is possibly only one that does not. We do not exactly have breakaway groups. As you know, some people set up ACPA as one of the groups. Some people—up to 30—left the society. Thirty out of 20,000 left. But the

other group I think you are referring to, the AAPi, is not a breakaway group at all; it is just a separate group that set up. They are actually not breakaway groups.

Senator FIERRAVANTI-WELLS: Professor, all I am trying to understand is where everybody is. It is obviously an issue that has created quite a degree of angst in the profession, and trying to find a pathway through is quite difficult. Certainly, as far as the staff are concerned, some of the behaviour of some of the witnesses and some of the things that our staff have had to put up with I think are quite appalling. It does not reflect well, might I say, generally on the whole profession.

Prof. Littlefield: Can I respond to that by saying that I do believe the APS itself, as the peak body, has not engaged in the type of behaviour you are referring to.

Senator FIERRAVANTI-WELLS: I am going to leave it at what has happened. For the benefit of trying to find a way forward for those millions of Australians, if their psychologists cannot get on, it makes you really wonder whether we are providing proper services out there. You talk about being the peak body. When did you first become aware of these changes?

Prof. Littlefield: To the Better Access cards?

Senator FIERRAVANTI-WELLS: Yes.

Prof. Littlefield: It was when the budget was announced. I became aware of them about half an hour before the lockup for the budget.

CHAIR: Can I just clarify that it was before the lockup, which is earlier in the day on budget day?

Prof. Littlefield: About half an hour before the actual lockup on that day.

CHAIR: But the lockup starts a bit earlier. So it was not just before the budget; it was towards the beginning of the day.

Prof. Littlefield: I think the lockup starts at five and I would have become aware of them about half an hour before that.

CHAIR: Thanks.

Senator FIERRAVANTI-WELLS: There are a few things in your submission. In terms of referral by health practitioners, are you not in favour of the GP involvement as the point of referral? Can you clarify that for me because it seems that you are saying it should all be in the psychology sector rather than with the GPs.

Prof. Littlefield: We are saying that we see the GP as the coordinator of a person's health care. Patients normally do go first to the GP, but we believe that as GPs refer to other specialities, if they have a consultation with the patient and see that there is a mental health problem, without necessarily doing a mental healthcare plan they should be able to refer directly to psychologists. We also see the GP in the role of coordinating care and we believe that there are cases were there should be items for that, payment for that. Some people definitely do need team based plans. So for those people the GPs are appropriate to do them.

Senator FIERRAVANTI-WELLS: In terms of these changes, have you had any involvement with the minister's mental health expert working group.

Prof. Littlefield: Yes, I am on it.

Senator FIERRAVANTI-WELLS: Were you aware of potential changes as part of your role there?

Prof. Littlefield: We were aware that Better Access was being looked at in terms of change, but not of any specifics to do with the changes.

Senator FIERRAVANTI-WELLS: I see. How many times did you participate in meetings of this mental health expert working group? Were there many meetings?

Prof. Littlefield: My memory says about three.

Senator FIERRAVANTI-WELLS: At those meetings no changes or cuts to Better Access were canvassed?

Prof. Littlefield: No specifics were canvassed. That is correct.

Senator FIERRAVANTI-WELLS: I would like you, if you could, to specifically have a look at the department's submission and, if you could, to just have a look at evidence that was given at the last estimates, particularly in relation this issue. It seems that the government is relying on work done by this working group in its changes to Better Access, whereas it is very clear from what you are saying that cuts to Better Access were not canvassed as part of the working group.

Prof. Littlefield: I have not seen that submission.

Senator FIERRAVANTI-WELLS: If you could kindly have a look at that, that would be very good. In terms of this shift of focus away from Better Access to ATAPS, do you think there are sufficient resources in ATAPS to cope with what is likely to be a huge move across? I understood two points from your submission. One is that you are talking about potentially 87,000 people who are going to move off Better Access and go onto ATAPS and basically you are saying that ATAPS is not geared to handle this amount.

Prof. Littlefield: That is correct. The 87,000 is based quite accurately on Medicare data. ATAPS has had more money put into it through the federal budget but very little comes in this year and it builds up. But even when it builds up it has absolutely nowhere near the capacity to take that number of people.

Senator FIERRAVANTI-WELLS: You say that the cuts are misguided. Do you share the concerns that Professor Jackson mentioned earlier in relation to how that data has been used? Do you have a similar concern?

Prof. Littlefield: I am sorry—what data?

Senator FIERRAVANTI-WELLS: The previous discussion about BEACH. Do you have any comments in relation to that as well?

Prof. Littlefield: I am sorry, I did not hear it.

Senator FIERRAVANTI-WELLS: Perhaps you could go back and have a look at that. I will stop there, Chair, as I am conscious of the time.

Senator MOORE: I want to focus on the proposed changes and see whether my understanding of them is correct. The numbers have been thrown around, but it seems to me that the core difference is the extra six consultations that can be done in exceptional circumstances. I know consultations go from 12 to 10 and those two consultations are very important—I do not want to dismiss that impact on clients—but the big cut is that last six. A range of submissions talk about the numbers and the document from the department. The minister's discussions focus on the review of the Better Access process looking at the numbers of people, according to that data, that accessed the final six sessions. Please focus on those final six sessions and the difference they make. I know you mentioned that in your opening statement. I am interested in the numbers of people that use those sessions and the options that people have. From your point of view, is that the cut—the final six?

Prof. Littlefield: The final six sessions are very important because the people who need them have moderate to severe or severe disorders. The data shows that they do use up to 18 sessions. What we found in our survey—I am happy to table it if the Senate would like a copy of the survey—

CHAIR: I think that would be extremely useful, thank you.

Prof. Littlefield: The survey has that sort of data in it.

Senator MOORE: This is data that you say is different to the data on which the Better Access review was done.

Prof. Littlefield: Yes, much different.

Senator MOORE: I wanted to get that on record.

Prof. Littlefield: There are 9,900 clients in our survey while the number in the Better Access evaluation was very—

Senator FIERRAVANTI-WELLS: This is the point that I was making earlier about the 1,300.

Prof. Littlefield: This is 9,900. It shows that we took pretreatment estimates of their degree of severity and then showed at the end of the 18 sessions, for those who needed them, where they were in terms of severity.

Senator MOORE: This is from your practitioners' clinical notes?

Prof. Littlefield: Yes, that is correct.

Senator MOORE: That is the way your data was collected.

Prof. Littlefield: It was collected from 1,180 practitioners who entered the data. You can see distinctly the drop in severity to mild symptoms or almost none after those 18 sessions. These are the people that need the treatment most. If it is cut off at 10, you will not get that result and where will they go. The data from our survey is very clear on the impact that is needed from those last six sections.

Senator MOORE: From your understanding of the data that the Better Access review used and the data from your members voluntarily coming forward, what is the difference in that data?

Prof. Littlefield: The first difference is the huge difference in sample size. The second difference is our data was based on clinicians' notes which were taken pre-treatment and post-treatment. We always do that as psychologists. The Better Access evaluation data was based on the K10 scale and the DASS scale. Clinicians

would have done that in our data as well, but our reporting was on their global assessment, putting those things together pre- and post-treatment. There are differences in the measures and in the numbers of clients that were assessed.

Senator MOORE: The Better Access review came out in late March.

Prof. Littlefield: Yes.

Senator MOORE: I know that people discussed that. We were all waiting for that review. That review was very clear about the number of people who accessed up to six sessions, the number of people who accessed up to 12 sessions and the number of people who accessed over the 12 sessions. At that time was there discussion suggesting people did not think the report was right or did not agree with the Better Access assessment and the findings of the Better Access independent review?

Prof. Littlefield: No, I sat on the Better Access evaluation. That was done very rigorously. The people who did it were questioned incessantly by the people on that group. The people on that group are real experts in evaluation. They are some of the best people in the country. The consultants who did that work were absolutely grilled about its integrity. The outcome from the report was examined. The report has seven components in it. All the detail that is there was trawled through reiteratively by the people on that committee. It was accepted as valid findings.

Senator MOORE: I am not going to try to quote the figures, but some small percentage of people in the overall scheme went through to over 12 appointments. That was accepted?

Prof. Littlefield: Yes, because there is Medicare data. The whole thing is based on Medicare data, so you can look at that and know exactly the number of people who had 10, 12 or over 12 sessions. We have also analysed our survey data, which I can send to you if you want—

Senator MOORE: Sure, why not.

Prof. Littlefield: We have analysed it up to the 10 sessions. Then we have analysed it from the 13 sessions upwards as well. We have broken down the different groups, if you would like that level of detail.

Senator MOORE: That would be very useful. Even though one can disagree over what period people get to know about things, a snapshot of the Better Access package tells us that there is no disagreement—there is a really small percentage of the overall group that go through to the 18 sessions. But your argument is on the impact that these cuts would have on the people who do go through. You are not arguing about the fact that there is a small percentage of people who move through it.

Prof. Littlefield: The low percentage is 13 per cent, and that is 87,000 people.

Senator MOORE: I agree. I just want to clarify that there is no disagreement that it is 13 per cent of the people using it.

Prof. Littlefield: No, because it is based on Medicare data.

Senator MOORE: As much of a guarantee as you can ever have on data, that is agreed?

Prof. Littlefield: Yes.

Senator MOORE: And your survey and your concerns that you are putting to us are about the impact on that 13 per cent?

Prof. Littlefield: Absolutely.

Senator MOORE: Okay, so that is the bottom line. The process used is dependent on a referral from the GP. So the first lot of sessions under Medicare go through. There does not have to be interaction between psychologists, GPs and patients, but there can be. If someone wants to claim, under the current circumstances, exceptional circumstances it has to go back to the GP?

Prof. Littlefield: That is correct.

Senator MOORE: Under the proposed changes, should it happen that you have seen someone for 10 sessions and you feel they need more, the process would be to go back through ATAPS, the public health system or they have to pay or drop out completely, which would be the worst case.

Prof. Littlefield: We are saying that ATAPS is unviable; it cannot accommodate it. The waiting lists for public health are months and months, and these are not the sort of people they take on. Private psychiatry was suggested as the other alternative. I asked the college of psychiatrists and they said they cannot find people that they can get in with a huge co-payment. The other thing about these people who are chopped off after 10 sessions is that they already have a therapeutic alliance with the person they are seeing. To break the therapeutic alliance you have to go backwards and start again. It does not make economic sense to go backwards and start again.

Senator MOORE: If they could find a psychiatrist who they could go to they would be able to get Medicare for that, but they would not be able to get any Medicare assistance if they chose to stay with their provider; they would have to fully pay for the end of that calendar year.

Prof. Littlefield: That is correct.

Senator ADAMS: Ms Hosie, on page four of your submission you made a statement that counselling psychologists are often better represented in regional Australia. I would like you to explain why that is.

Ms Hosie: I do not have any figures here in front of me but I could find those for you. I know we are widely represented across Australia. Unfortunately, as a result of Better Access, we have lost so many courses and our numbers in universities are diminishing, but counselling psychologists are certainly widely represented across Australia. If you want data on that I can try and get it, if it exists; I am not sure if it exists.

Senator ADAMS: I was just wondering about that statement that they are far better represented. Why would counselling psychologists be more prone perhaps to go to regional Australia rather than practising elsewhere. Could you explain that?

Ms Hosie: With counselling psychologists there is an emphasis on working in the whole system of the person and they are trained in community settings and take a community focus. That would be one reason why counselling psychologists would be drawn to regional areas. I really cannot expand beyond that at this stage. There is an emphasis in our course on working with communities and in community settings and that is easier to do in a rural environment than in a suburban environment.

Senator ADAMS: Do you know anything about Indigenous communities and what sort of psychologist is more prevalent there? I am just trying to get an idea of what attracts counselling psychologists out to those areas and if they are actually in the Indigenous communities as well.

Ms Hosie: There are counselling psychologists who work in Indigenous communities and I know there are a number in Alice Springs and in Darwin. I cannot talk on their behalf as to why they are drawn to those areas, other than saying that I think it is something about the type of training in counselling psychology and the emphasis on working with the whole system and on welfare issues. I cannot comment beyond that, but I know they certainly do.

Senator ADAMS: Have you had any feedback from any of these people who are in the more outlying areas as to how they will cope with the number of sessions being cut, given that their visits probably are not as frequent as they would be for someone who lives in the metropolitan area. Have they come back with any feedback on that?

Ms Hosie: Yes, we have had feedback about the importance, as Lyn was saying, of those extra six sessions. They are often working in communities with people who are severely disabled by mental illness, and those extra six sessions really do make a difference in getting better outcomes. As we all know, some of those rural communities are extremely troubled. I have heard a counselling psychologist talk about that and the importance in those areas in particular of the extra six sessions.

Senator ADAMS: How closely do your organisations work with the divisions of general practice?

Prof. Littlefield: Very closely. For instance, I sit on the Australian General Practice Network committee that is working on the transition to Medicare Locals. We have a partnership with the Australian General Practice Network to do with the ATAPS initiative. We partner with them: we look at the quality of that initiative and the services delivered, whereas they look at the dissemination of the services. In relation to the College of General Practice, we have an organisation called the Mental Health Professions Association where there are four partners. Both us and the College of General Practice our partners in that, as we are partners in the Mental Health Professions Network, which rolls out networks of professional mental health providers across Australia. So we have very, very close relationships with the GP bodies.

Senator ADAMS: That leads to the next question, on the Medicare Locals. How do you see the transition between the two with the general practice being phased out as the fundholders and the Medicare Locals taking over? Could you give us some idea about that.

Prof. Littlefield: I think that it is very, very early days. I do sit on the transition committee and hear what is occurring. As far as mental health is concerned, I think that they are going to take over the management of ATAPS and other mental health programs. I am particularly keen to have on the boards of the Medicare Locals people who understand mental health because it is part of the business. AGPN has now been invited, I believe, to form the overarching body for the Medicare Locals and, I believe, also on the board. Because it will be a policy setting, implementation strategic board, there should be people with mental health expertise on that board too, because mental health programs are going to form quite a substantial part of the work of the Medicare Locals and

the overarching body of the Medicare Locals. At the moment, I have not been given any firm undertaking at all as to whether that will happen, so to answer your question, I think that it is early days and it is unknown.

Senator ADAMS: As far as any practical involvement with one of the 15 Medicare Locals that have been announced, do you have any close association with one that is starting up?

Prof. Littlefield: The Australian Psychological Society has alerted its practitioners to where these Medicare Locals will be sited as they are announced. Our body, along with Allied Health Professions Australia, is actually building networks of allied health professionals including psychologists around the Medicare Locals. These bodies will help Medicare Locals to be truly primary health focused on general practice and other health services including mental health. We are wanting to get them involved in the establishment of the Medicare Locals and get them onto clinical reference groups which, I believe, are going to be set up around the Medicare Locals. So we are actually doing a lot of work—believe me, it is a lot of work—to get the Medicare Locals to be truly primary healthcare focused and to have the right expertise on them to make them very effective and, particularly in this case, in the mental health sector.

Senator ADAMS: Medicare Locals are much larger than the division that would have been there, which may be a group of three or four or five. I come from Western Australia and I can assure you that the Medicare Local that has been set up in the area that I come from is huge, and, having had the experience of a number of regional health services within that area, I am very, very concerned about people on the ground actually receiving the care that they should get. I just think that it has gone far too far. It was very difficult when there were health service regions but now that you have got all those together it is going to make it even more difficult, and mental health services in that particular area would have to be one of the key groups that is really necessary.

Prof. Littlefield: This is the importance of the Mental Health Professionals Network. It is setting up local groups of mental health providers so that they know one another, form networks, and form teams based care for the benefit of mental health consumers. They are in much more local areas than the big conglomerates that you are talking about with Medicare Locals, which cover huge areas.

CHAIR: I want to follow up the issue around advising the expert panel. The APS was not on it originally, is that correct?

Prof. Littlefield: That is correct.

CHAIR: Was that seen as an oversight? How did it come about that APS was then added, or that you were? I do not think that it was represented. It was a group of experts.

Prof. Littlefield: Yes. There was a psychologist originally on that panel. Andrew Fuller was his name and he is a member of ours. He could not take part in the panel and so I was then recommended as an individual on it.
CHAIR: You are not listed on the official listing so I just want to clarify that.

Prof. Littlefield: But I was there from the beginning—Andrew dropped out before the first meeting.

CHAIR: From the evidence you have just given I am clear that the panel did not recommend cuts to the minister. Did the panel consider the report on Better Access and provide any advice on Better Access itself—that it is working, or any changes that could be made in light of the review?

Prof. Littlefield: There was a discussion about it, without doubt. There were two aspects to the discussion. One was that I think everyone there agreed that it was an extremely positive report, from that evaluation. It almost, in some ways, could not have been better—we had an initiative that the data showed was effective, people were actually improving significantly from treatment; it was being taken up by a huge number of Australians, I believe over two million, so the need was there and it was meeting that need; and the most important thing was that it was very cost efficient. The issues with it, which were discussed, were that I believe like all other Medicare items you get more people taking them up in the metro areas than you do in the rural or lower SES areas. It is actually no different to any other Medicare item. But the group would have agreed that we do need to target these people—there is no question—and hence ATAPS is appropriate for targeting these people.

CHAIR: I am very conscious of not asking you to breach confidentiality of the panel, so I will push the boundary until you think it is uncomfortable. You have gone to the area I was going to next, and that concerned issues around rural and regional, SES and understanding issues around provision of services for Aboriginal communities. Did you provide advice or give some thought to recommending how the government could focus resources? You have just mentioned ATAPS. Without telling us what you said, because I realise that is probably breaching the line, did you turn your mind to those issues?

Prof. Littlefield: I guess there was no mention of cuts to Better Access—it was not like looking for what we could do instead.

CHAIR: Did you provide advice on how you thought you could improve access across the delivery of mental health programs for those particular sector groups or community groups?

Prof. Littlefield: It would have been at the level of we do need more targeted programs for those particular groups. I am honestly not sure whether we said we needed ATAPS for them—we needed targeted programs for them.

CHAIR: Moving slightly away from Better Access—because I understand what you are saying—and to the other programs that are being provided through the overall additional funding that is going to mental health, and the terms of reference asked us to look at other programs, leaving aside the changes to Better Access and the fact that some of the funding has been taken to put into other programs, if we had a big bucket do you think that the other programs are well targeted and are they appropriate?

Prof. Littlefield: I will mention a couple that I can think of. I think the flexible care packages are a very good idea. I think people with severe and persistent mental disorders of the low prevalence type, which is schizophrenia, bipolar et cetera, do need team based care and they do need coordination of it. My hope is the appropriate people will be employed, if that is the model, to actually provide appropriate clinical care as well as the non-clinical support services. The clinical care of these people is quite specialised. That is number one. Number two, I think it is good to focus on mental health promotion, prevention and early intervention and therefore expansion of headspace is a good idea. I think the child area is absolutely necessary to expand. The literature says and practice says you can pick up children, some of them, right from birth who are vulnerable and will go on to develop mental health disorders. You can pick them up in child care, you can pick them up in schools. There should be much more money focused on children. I actually believe the spread is out of kilter. If you like to name some of the others—

CHAIR: You picked up some of the key ones that I was thinking of. The Health Commission?

Prof. Littlefield: I think that is a very good idea. In my view it should be independent of government. It should be an independent body. I think it should be a body that looks at transparency, accountability and evaluation of the money that is spent in mental health. In those respects I do think it is a very important body. It should give advice as to the best services possible for what we want to do. It needs real experts on it.

Senator FIERRAVANTI-WELLS: Not tucked away as a unit in the Prime Minister's department.

Prof. Littlefield: I personally believe it should be independent.

Senator MOORE: My question is about ATAPS. We have had a number of submissions as well as comment in your own and from the previous witnesses which say that ATAPS spends too much money on bureaucracy.

Prof. Littlefield: I think ATAPS is quite expensive, in part for good reason. It is targeting niche groups which are quite difficult, such as homeless people, Indigenous people, people that are suicidal, et cetera. You do need to spend money sometimes on outreach. It is not all in the office and so forth. ATAPS is run through the divisions at the moment and Medicare Locals in the future that take a cut for administration. I personally do not see the need for that happen. I think it can be direct referral through the GPs like Better Access is. It is just a much more expensive service. I have seen the figures. It costs two to 10 times more per session to what Better Access costs.

Senator MOORE: We will be targeting the department as well. The justification for that is the focus and need on targeted groups.

Prof. Littlefield: Yes. I guess what they want is a capped service in terms of funding with a body like a Medicare Local managing the funding. The big problem with that, and will continue to be the problem with the amount of money that is put in, is that those caps are going to get reached incredibly quickly. We are going to have the same situation where a division or Medicare Local will run out of money part way through the year. I do not know how they will ration it. Then people could be without service again.

Senator MOORE: The difficulty of eligibility was raised by the previous group that, because it is focused on specific groups, people with need will not be eligible for the services.

Prof. Littlefield: Some will not, but there is a general component to ATAPS as well so you can get in under that. The other difficulty with having it managed under Medicare Locals or divisions is they are money conscious.

Senator MOORE: They are businesses.

Prof. Littlefield: They are businesses. They try to find the psychologists they can get for the lowest possible salary.

Senator FIERRAVANTI-WELLS: More junior psychologists.

Prof. Littlefield: Yes, juniors and first out, the really green psychologists in a number of cases.

Senator FIERRAVANTI-WELLS: The point is that you are shifting people with severe problems to ATAPS and you are going to have the least qualified, if I can put it in those terms, dealing with these severe issues. That is it in a nutshell.

Prof. Littlefield: It is a great worry of ours.

Senator MOORE: Could I use the verb 'may' rather than 'will' because I know across the board many of your quite experienced members work in ATAPS as well. It is a concern but it is not necessarily that people in ATAPS will be under qualified.

Prof. Littlefield: I was going to say that. You are right. It has been a problem but there are a range of people. Because the money is much lower for the psychologists you do not tend to get the very experienced ones and because now it has become such a niche program to these hard-to-deal-with groups you want the most experienced psychologists there. You actually want people that have really good training in those niche areas. That is a worry.

Senator MOORE: I just wanted to get some more comment on the ATAPS plan as that is the one that is getting more funding. If that is getting more funding, I want to know the reasons why and the problems you see in it. Thank you.

Senator FIERRAVANTI-WELLS: But the bottom line is that, whether you shift the money from one area to the other, proportionately, in the end we are still going to have fewer people treated. That is the bottom line. There is total agreement across the sector in relation to that. I have a question in relation to the adequacy of funding in services for disadvantaged groups. Professor, your comments in relation to these three groups are very general. You obviously do not have specific information in relation to them. Is that because it is not within your purview or you do not specifically have the resources? Could you explain that to me a bit more.

Ms Giese: The reason there is only brief information in this is because we were focusing on the terms of reference that were related to the Better Access cuts. We certainly could furnish you with more information.

Senator FIERRAVANTI-WELLS: Would you? All the terms are important. I appreciate they were the first two, but I would appreciate it if you could focus on these. Madam Chair, as a general observation, people did focus on the Better Access part. We included this so people could provide us with that detail.

Prof. Littlefield: We have the Australian Indigenous Psychologists Association. There are only 45 Indigenous psychologists in Australia. We have very good information on the Indigenous community.

Senator FIERRAVANTI-WELLS: You said you have 20,000 members. Can you give us a breakdown of where they are? If it is available in a public place, just let us know.

Prof. Littlefield: In terms of states or rurality?

Senator FIERRAVANTI-WELLS: Right across. Whatever statistics you have as to where those 20,000 are and what they are.

CHAIR: I really love enlightenment. Has there been the same sort of assessment of ATAPS as there has been of Better Access? I am aware of the ANAO report, but that is based more on administrative governance and things like that.

Senator MOORE: It does not go into the clinical stuff.

CHAIR: It does not go into the clinical side of it. Has there been—

Prof. Littlefield: There has been ongoing quite good evaluation of ATAPS done by exactly the same crew who did the Better Access evaluation components A and B. That is ongoing. Sitting here I am not sure I could tell you the detail of whether it matched exactly, but there is an evaluation.

CHAIR: We will chase it up because, as Senator Fierravanti-Wells has pointed out, there has been a lot more comment on Better Access than ATAPS. It is very clearly part of our terms of reference. We would very much appreciate any more thoughts that people have. I am addressing this to the general audience as well. If you have any additional thoughts, we would gladly receive them. You have some other homework in terms of some specific questions Senator Fierravanti-Wells asked and I think Senator Moore too. If it is unclear, the secretariat will have it.

Senator MOORE: Ms Hosie as well in terms of the counselling psychologists. The issue about the different payments for psychologists and the levels is not a new one. Can you confirm that for me, both from the full association and the college? The amount of angst that we have had reflects the kind of angst we had in previous mental health inquiries. I think it is important to put on record that this is not a new issue. It continues to be important, but it has not been stimulated by the recent process.

Ms Giese: It has been present since 2006.

Senator MOORE: I think it was present well before that.

Ms Giese: When people got their Medicare access—

CHAIR: That is right. This pain—and it is pain—with the profession is not new.

Prof. Littlefield: It is pain.

Ms Hosie: I have been on the national incentive for 13 years at my college. It has certainly been there a lot of that time. There has always been a tension between the similarities and the differences between counselling and clinical psychology. About 70 per cent is very similar but there are differences in philosophy and the delivery of the service. I have been the national chair for five years and I could give you reams of abusive emails that I have had in those five years.

CHAIR: I do not really want to reopen that.

Ms Hosie: The wounds run very deep.

CHAIR: You did mention that the Indigenous psychologists are members of yours. If there is any additional information you would like to send us on specific access to services in Indigenous communities, that would be very much appreciated because, as you know, that is one of the areas that has been highlighted through this process.

Senator MOORE: Can we just add to that the multicultural one as well because I know you have groups that look at that as well. If we can get specific data on those two areas—

CHAIR: That would be very much appreciated. The secretariat will let you know when we would like your homework. Thank you very much.

Prof. Littlefield: And the documents I offered as well?

CHAIR: You can table it now with the secretariat or send them in—

Prof. Littlefield: It might be better if we send you a set.

CHAIR: That would be great. Thank you.

Proceedings suspended from 10:51 to 11:11

BRETHERTON, Dr Lesley Faye, Founding Member and Chair, Victorian Section, Australian Clinical Psychology Association

CICHELLO, Mr Anthony Michael, National Chair, Australian Psychological Society College of Clinical Psychologists

HYDE, Dr Judy, President, Australian Clinical Psychology Association

LEONARD, Ms Erika, Chair, Board of Assessors, Australian Psychological Society College of Clinical Psychologists

CHAIR: I welcome representatives of the Australian Clinical Psychology Association and the Australian Psychological Society College of Clinical Psychologists. I understand that information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. We have your submissions. I remind you that evidence should address the terms of reference of the committee and misleading the committee may constitute a contempt. We ask that witnesses avoid making adverse comment against other parties and warn that such reflections may prompt the committee to suspend proceedings. The committee may decide to take evidence in camera at any stage and witnesses are able to ask to give evidence in camera if they so wish. Would anyone like to make an opening statement?

Mr Cichello: Ms Leonard and I are here to represent the APS College of Clinical Psychologists, representing approximately 4½ thousand members of our college, which is the largest college within the Australian Psychological Society. The reduction in better access rebates and session numbers for Australians with acute mental illness—estimated at approximately one in five within any one year—and transfer to ATAPS for the treatment of the moderate to severe range of mental illness threatens that those Australians with acute mental health disorders will not receive adequate treatment by specialised clinical psychologists.

Clinical psychology is an internationally recognised specialisation in psychiatric disorder within psychology in its specialised body of knowledge, skills and practice. Apart from psychiatry, ours is the only mental health discipline whose entire APAC and PsyBA—that is, the psychology registration board—accredited and integrated postgraduate professional training exclusively and comprehensively specialises into an advanced, evidence based and scientifically informed training of psychopathology, assessment, diagnosis, case formulation, psychological treatment, psychopharmacology and clinical evaluation and research across the full range of severity and complexity of the life span. We are well represented in high proportion amongst the innovators of evidence based mental health therapies, NHMRC clinical panels and other mental health research and clinical leadership positions. It is the specialisation of clinical psychology, psychiatric disorder, which relates exactly to the intended conceptualisation behind tier 2 within Better Access.

We are one of nine equal specialisations within psychology. We all now require a minimum eight years training, including a further APAC accredited postgraduate training in the specialisation leading to an advanced body of psychological competency in that particular field. Whilst all areas of specialisation in postgraduate training undertake further minimal training in mental health, it is not sufficient to qualify as an exclusive and comprehensive specialisation within that field. For example, clinical psychologists do undertake some minimal further training in neuropsychology, yet we do not comprehensively and exclusively specialise into the body of knowledge, skill and practice of that particular specialisation.

As is the case with clinical psychology currently, our college believes that each area of specialisation deserves a specialist rebate with its own particular item number pertaining to that which is the specialist domain of that area of psychology. For example, for clinical neuropsychologists it would be a specialist item pertaining to neuroanatomy, neuropsychological disorders, assessment, rehabilitation and so forth. For the health psychologist, for example, it would be clinical health psychology and health promotion and for forensic it would be forensic mental health, and so forth. Our unique specialisation is psychiatric disorder. We do undertake some minimal

training in other fields but we do not specialise in those other fields. That is what makes us a separate specialisation.

No specialisation should be referred to in a manner that creates the appearance of the same level of skill and knowledge as the undergraduate, academic, APAC accredited four-year training of a generalist psychologist. The Psychology Board of Australia advises that the specialist fields of psychology areas of endorsement will further inform the nature and structure of future industrial awards. The work value of clinical psychology was recently demonstrated within Western Australia in 2002 via a hearing of the full bench of the Industrial Relations Commission and we have tabled this document and associated documents from that process and associated reviews from Britain and Scotland for your reference. It is worth noting that international comparisons are very tricky. No-one without a professional doctorate can be registered as a psychologist in the United States of America for instance, where there is also a Medicare program. Therefore, there is only one layer of psychologists in the United States—just a comment about international comparisons.

Ms Leonard: There are a couple of points that I would like to draw your attention to. One is about the Better Access evaluation and the measurement instrument used there. Dr Hyde has written some very good comments on other features that make this a rather poor quality study, but I will draw your attention to the measuring instrument—the DASS, depression, anxiety, stress scale—that was used to find the outcome. The outcome was that, after five or six sessions on average of seeing a psychologist, most people's score on this scale fell considerably. But what the scale measures is general distress. It does not measure psychopathology or mental illness.

If you want to look at what clinical psychologists do as specialists, in comparison with other psychologists, both specialists and generalists, you need to look at any change in the mental disorder that the patient has—not just whether they are feeling a bit better or a bit more comfortable, which is really all that study shows. It is reassuring to know that most psychologists can make their clients feel a bit better and a bit more comfortable, but what we really want to know is what has happened to their mental disorder. Has it been treated and eradicated or is it still present?

For the last 50 years, the whole international discipline of clinical psychology has been developing treatment interventions that actually treat a large proportion of the acute mental disorders, particularly the high-prevalence disorders, so that the patient becomes well and returns to healthy and normal functioning. But that same body of literature—decades' worth in the journals—shows that it takes 20 sessions on average to accomplish this actual treatment result. It is not 12 and not 10; the average is 20. The journals are just full of it—all different kinds of conditions and so on. It is around 20 for most conditions. We have not had 20. For a few cases, we have had 18—if you could demonstrate those special circumstances—and it looks like, maybe, people did get quite a lot better with those extra sessions. However, that research has considerable flaws in it as well.

What you need in order to allow clinical psychologists to deliver proper treatment services to those members of the Australian public who have a mental illness is to let them have 20 or even more sessions available so that the clinical psychologist can actually treat to the end point of treatment rather than cutting treatment off prematurely. If treatment is cut off prematurely, you can imagine what happens—the patient has been getting a bit better but now relapses. You get the rotating-door phenomenon. This has still been happening under Better Access, although it has been better than nothing.

Now would be a marvellous time to expand those arrangements—to give clinical psychologists who deliver full treatments the opportunity to do so and to demonstrate what it is they do. This would actually cost the government nothing because those psychologists are going to fill their diaries with patients anyway. There are about 4,000 of them and, if they did see people for as many as 20 sessions, that body of 4,000 psychologists would treat a quarter of a million Australians. There are probably 2 million Australians who, at any one time, have a mental disorder—some estimates would be higher—but not all of those need to see a clinical psychologist. I think we are reaching the point where it might be useful to engage the clinical psychology workforce in its proper form, rather than having fewer sessions.

I am not saying whether or not you return the other sessions to a higher number, because the other services—focused psychological strategies—are probably what do take five or six sessions to deliver. It may be satisfactory to leave that as it is or to leave it as proposed in the budget. But if you cut clinical psychology, you are removing the core treatment. The only other treatment there is for mental disorders is psychiatric treatment. The core treatment otherwise comes from the profession of clinical psychology, and to treat it you as if it were the same as general psychology and just drop its numbers—because a study which had 80 per cent general psychologists and 20 per cent clinical psychologists in it shows an average of five to six sessions—does not display what clinical

psychologists can do if they are given appropriate opportunity do it. Then those people will be treated and they will be well. That is the main thing that I would like to say.

I can also comment on the fact that you are having before you some people who are saying, 'We think that we are equal to clinical psychologists. We should be treated equally.' Those people have had 4½ years to apply to the Medicare assessment team at the Australian Psychological Society commissioned by the Commonwealth government itself to assess such applicants for assessment of their equivalence to a clinical psychologist. There have been 1,500 such applications. It was agreed that some of those people did have the same standard as clinical psychologists, another group were given bridging plans because they were close to that definition but not quite, and others were told that they were unsuccessful and would need to do a full master's degree in clinical psychology if they wanted to become a clinical psychologist. That process has been available to all psychologists. Fifteen hundred have availed themselves of it, and I don't know whether much weight should be given to those who are complaining today that they are equal if they did not avail themselves of that opportunity.

I am the chair of the board of the clinical college and I liaise between that Medicare team making those assessments and the college to make sure that the standards of the clinical college are upheld, and I confirm that indeed they were upheld. There has been no lowering of standards.

CHAIR: Thank you.

Dr Hyde: The Australian Clinical Psychology Association, or ACPA, would like to thank senators for their time in consideration of these really important matters and also to say that we agree with Senator Fierravanti-Wells that the profession is in great distress and great pain at the moment and we need to work out a way to move forward. We would like to be a part of that way of moving forward.

ACPA represents those clinical psychologists who meet the standards for endorsement of the Psychology Board of Australia. These qualified clinical psychologists undertake four-year postgraduate training either as a master's, which is two years, or a doctorate level of three years, plus a supervision program which continues on to complete the four years. This training is focused entirely on mental health assessment, diagnosis, formulation, treatment and implementation of outcome studies. So one of our areas of expertise is the outcome study.

The Australian Psychology Accreditation Council is the accrediting body for psychology programs across the country. Accredited training ensures the attainment of a recognised standard of professional practice through continual academic, clinical and research learning and examination of knowledge, skills and clinical acumen over a variety of settings with numerous clinical academics and supervisors. No other professional group other than psychiatrists has the same level of training. As Ms Leonard said, these qualified individuals are currently poorly differentiated and are underutilised in the mental health system.

To address the terms of reference in brief commencing with the decision-making process for the changes to the better access program, it is very evident that the key stakeholders in the better access program—GPs and psychologists—were not consulted adequately before reductions in funding to these services were announced. It is unclear the basis on which these cuts were made.

Decision making regarding funding of mental health programs needs to be transparent, accountable, consultative and with decisions based in the evidence of what is effective. Qualified clinical psychologists need to be involved in the decision making regarding mental health programs as they, like psychiatrists, have extensive accredited postgraduate training specifically in mental health. ACPA would like to stress that decisions must not be made on the evaluation of the better access to psychiatrists, psychologists and GPs through the Medicare benefit schedule, and in my submission I have outlined the reasons why this is an extremely flawed study. It breaches virtually every fundamental tenet of a properly formatted and implemented research project as an outcome study.

Other indications are that things are not so good. 47 per cent of patients represent to better access year by year. As an Ms Leonard talked about, this is a revolving door syndrome and may well be related to lesser treatment or inadequate treatment. This needs to be looked at to determine the factors leading to this free presentation and how we can address these. The differentiation between mild, moderate and severe mental health problems in determining what sort of services patients require is fundamentally flawed. There are many patients with mild presentations who have chronic issues that have gone on for many years and high levels of comorbidity which are not assessed by GPs. They are very good at picking up anxiety and depression and they do have some limited knowledge in other areas, but they do not always pick up the more severe comorbid problems that go along with anxiety and depression.

Moving patients with severe or moderate mental health problems to psychiatrists, the public health system or ATAPS is not a satisfactory solution. Psychiatrists provide excellent medication and advice; they charge high co-

payments and they are undersupplied. A vast majority of them do not provide psychological services like therapy; they stay focused on the medical model of providing medication. They often work in conjunction with clinical psychologists, who provide the psychological therapies for them.

The concern that we have about ATAPS is different from what has been raised here this morning. One of the issues is that ATAPS is currently restricted to providing only focused psychological therapies or strategies. These are generally provided by less well trained clinicians than qualified clinical psychologists. Qualified clinical psychologists under Better Access are enabled to provide broader services using multiple models and they are given a higher tier rebate to provide these services. However, the ATAPS focuses totally on focused psychological strategies, which is a very limited type of intervention, certainly developed by a clinical psychologist for implementation by other health professionals, but if we are going to move more severe patients into that ATAPS group we need to have higher levels of qualifications. We have found amongst our members that, while many of them are in the ATAPS program, where they are given greater freedom and acknowledged for their experience and qualifications, they are happy within the program. But many withdraw from it because they are restricted by GPs in the way they want to implement that program with them. As Dr Littlefield said, the ATAPS program also has some of the newer members of our profession going into it. There is a wide variety, but we are concerned that there is no differentiation and no way of determining whether the practitioner actually has the qualifications required for treating the more severe presentations.

What is needed for the funding of mental health is an overarching plan for service delivery that integrates programs and enables patients to move between the types of programs they need. So, if they become severely unwell, they can access the public health system and the resources there but move back into less restricted practices, such as the Better Access program, when their condition improves. We need to look at chronicity: just like physical health, there is also a mental chronicity that is not addressed by Better Access. It is addressed in the ATAPS and public health systems but may be better serviced in a less restrictive environment, like in the private health system. The number of sessions allocated to patients needs to be determined by the presentation they have—their comorbidity, chronicity and level of severity—not just by an arbitrary number that is picked out by economists. Services need to be provided by the people who are qualified to apply them at each level. This needs to be worked out, and a mental health commission might well help us with this. However, on that commission we need experts. We may need some representation from professional bodies like our own and others, but it needs to have experts working in the field and we need representation from our psychology board.

I move on to issues relating to the profession of psychology which have so divided us in recent years. Australia has the largest but most poorly trained workforce of psychologists in the Western world. Eighty to 85 per cent of psychologists currently practising in Australia would not be permitted to use the title of 'psychologist' or provide mental health services to patients in any other country in the Western world. The standard for specialisation in Australia is also poor. It is estimated that—I am not sure of the figures Ms Leonard has just given us—not quite half of the clinical psychologists who are endorsed as clinical psychologists do not hold the qualifications established as the minimum standard for clinical psychology by the Psychology Board of Australia. In most other Western countries, a doctorate level is required. In Australia we require a master's level. We want this moved up. ACPA is deeply concerned about the lack of recognition of the value of the accredited mental health training and expertise of qualified clinical psychologists, both within our profession and outside of it. There is two-tiered training for psychologists. The two-tiered Medicare rebate system needs to be retained as it recognises the value of accredited postgraduate mental health training of clinical psychologists and the specialised skills that this training brings. It is extremely rigorous training. I am involved in that training. I have also been involved in the training of counselling psychologists and I could comment upon that if you would like.

One of the issues with training is that students are not provided with Centrelink living allowances if they do a doctoral program which would reach international standards, not even at the level of a master's program. So they do not get that allowance at all, whereas master's trainees do get that allowance. The other problem with training our highly specialised clinical psychologists is that the courses are underfunded. We are not able to actually run it such that it breaks even. I know in the last years the University of Sydney, which runs only a doctoral program, ran at a loss per student of over $6,000 a year.

Just to summarise, practically speaking, if you or someone you loved suffered with a mental health problem, who would you choose to treat them—a psychologist with a general undergraduate degree and no accredited training in mental health; a psychologist with a specialisation in an area other than a mental health but with some partial training in mental health which is accredited; or a specialist in mental health, a clinical psychologist who has undertaken a rigorous postgraduate degree focused on mental health with numerous points of examination by multiple clinical academics and supervisors? If you chose a qualified clinical psychologist, how would you find

them? There is just no way to differentiate them currently. The only way to assist you and to enable referrers and the public to identify those with the qualifications and expertise they wish to employ is to grant specialist titles to all specialties in psychology, all those with accredited postgraduate training in the specialties of psychology. I do not believe a professional body should be given the role to administer any aspect of any government funding program.

In conclusion, I would like to say that through ACPA qualified clinical psychologists want to be an integral part of the solution to the problems within the mental health sector and within our profession. We want to assist in the construction of an accessible, flexible and integrated mental health system, tailored to the needs of patients at all levels of severity, working in conjunction with other mental health experts, such as psychiatrists. Thank you very much for having us here today and allowing us to contribute to this debate.

CHAIR: Dr Bretherton, did you want to say something?

Dr Bretherton: I would just like to add two short points to Judy's presentation relating to the possible effects of cuts to the Better Access initiative on the public mental health system and especially on the paediatric sector, which I consider a disadvantaged group. The first point is that the introduction of the Better Access initiative in 2006 led to an exodus of experienced clinical psychologists from the public sector into private practice. This, in turn, led to higher workloads for the remaining clinical psychologists, difficulty recruiting experienced staff, longer waiting lists and therefore reduced access to public clinical psychology services. It also reduced the training capacity for postgraduate clinical psychology students in teaching hospitals, such as the Royal Children's Hospital. If the number of rebatable sessions is reduced, this will put a further strain on the public system because patients will not be able to access sufficient sessions privately and so they will be referred back to the more expensive public system to take up or continue treatment.

The second point that I want to make is about early intervention. Early intervention for mental health should be available from birth or even prenatally. Many children under 12 require intensive psychological treatment. For example, Growing Up in Australia: The Longitudinal Study of Australian Children reports that 14 per cent of Australian four- to 12-year-olds were found to have multiple behaviour problems that placed them in the clinical range, which is severe behaviour problems. These children often come from disadvantaged households. These children often come from disadvantaged households. Parenting difficulty is robustly related to the development of behaviour problems in children. Therefore assessment and treatment of young children requires intensive work with parents. However, parent-only sessions are not eligible for a Medicare rebate. Parent sessions are vital to evidence based psychological treatment of child behaviour and emotional problems and should be eligible for rebates when the treatment pertains to the child. It is not appropriate and it may be detrimental to require children to be present in parenting sessions. Parenting work is the norm in the public sector but is often out of financial reach for many parents who need it in the private sector. Thank you

Senator MOORE: I have a couple of questions. They are to do with the response to the assessment of better access. Dr Hyde, you have put a number of points in your submission. Did you raise that at the time with the people who were doing the evaluation?

Dr Hyde: No. We are a very new organisation and I am still learning about the landscape of mental health and we have not been invited to the table on any things as yet. However, we have requested meetings with the minister and with Mr Butler but we have not had them yet.

Senator MOORE: That is my next question. I picked up on that particularly. I think it does not matter which government is in power and I still ask these questions. It says here specifically that you did request a meeting. Can you give me the details of that—maybe not on record, but I will get them. I take it very seriously that you have done that.

Dr Hyde: We have had several campaigns going to the ministers but we did send a letter requesting a meeting which—

Senator MOORE: How long ago was that?

Dr Hyde: It was several months ago.

Senator MOORE: So some of it was to do with your concerns about this assessment process?

Dr Hyde: Yes, but we did not outline that in the letter. We just requested a meeting to discuss multiple concerns and we have subsequently also requested a meeting with Minister Plibersek.

Senator MOORE: For some Centrelink issues?

Dr Hyde: Yes. But we have had a very good response from our local member, Paul Fletcher, who has been helpful in assisting ACPA to—

Senator MOORE: That's in Melbourne?

Dr Hyde: No, he is in Ku-ring-gai in Sydney.

Senator MOORE: I am sorry; I do not know.

Dr Hyde: He is a Liberal shadow minister.

Senator MOORE: North Sydney?

Dr Hyde: Ku-ring-gai.

Senator FIERRAVANTI-WELLS: Paul is in Brendan Nelson's seat.

Senator MOORE: Right.

Dr Hyde: He has been helpful with us. We went to him initially and talked about our issues and he has been supportive of us.

Senator MOORE: And that has been in the last couple of months?

Dr Hyde: That has been over the last 18 months. We keep him informed of what we are doing.

Senator MOORE: A lot of the focus in the submissions from both organisations has been around the issue of qualifications and skills base and you know in the government process there has not been a consideration, but it is appropriate to bring it forward in terms of the general issues of mental health. The focus of this particular inquiry is around the whole range of changes that have been brought in. I am not going to get into the issues around the number of sessions. You have fully explained your concerns as to that and I accept those, and all that will go into the process. I am interested in this as we have this opportunity. Dr Bretherton, you did mention particularly paediatric services and that was a new point which we had not had before. Would any of you like to make comment on any of the other terms of reference that we have for this inquiry and on other changes that have come in in this process? I am specifically giving you that opportunity.

Dr Hyde: I think it has been well covered.

Senator MOORE: That is fine; thank you. Dr Hyde, I will follow up with you about the other stuff.

Senator ADAMS: I would like to continue with a theme that I have had, with the divisions of general practice ceasing and Medicare Locals taking their place as the funding body. Have any of you any comments to make? I note, Mr Cichello, that on page 10 of 12 of your submission there is a concern that you are raising as to the divisions of general practice and the area that they take up in comparison to what will happen with Medicare Locals because it is a much larger area. That is the first thing. My second question is on employment. You are concerned that the divisions at the moment frequently employ general psychologists rather than clinical psychologists.

Mr Cichello: Yes, it is based on a couple of sources of information. Firstly, I am a previous director of mental health services in several Melbourne based divisions of general practice, so I have direct background experience of the administration and recruitment of providers into those programs. Secondly, we have 4½ thousand members who regularly send me correspondence. For example, I have had more than 1,000 members email me since this very good inquiry was announced to comment on their local experiences.

On the basis of the department funding figures, to the best of my capacity I did a back-of-envelope estimation of the amount of actual funding which was related to the new funding into ATAPS, particularly the FCP, the tier 3, the new persistent and severe mental illness. I think the AMA submission covered this extremely well. I did a back-of-envelope estimation of what that drills down to on the basis of the current divisional structure—because I cannot really understand yet what the Medicare local structure will look like in totality—with approximately 126 divisions of general practice and much of this new funding not coming through until years four and five of the announced five-year cycle in the budget. I looked at it on the basis that 50 per cent of the focus of this new money is to be direct clinical interventions into this client cohort and 50 per cent nonclinical support. I took out the overheads and the operational costs associated with running any program—for instance, when I was a manager in Melbourne Health I lost 40 per cent of my budget for a primary mental health team before I even saw it. You are looking at something like $260,000—and please do not literally quote me—per current division area.

This really equates to something in the order of two to 2½ EFT of an experienced clinical psychologist. This is really the appropriate type of workforce to provide clinical interventions to persistent and severe mental illness of the type of evidence based therapies which are known to produce change for nonacute psychosis including schizophrenia, bipolar and so forth. It is really looking at a landscape possibly where you have two to 2½ clinical psychologists providing services. That may or may not be sufficient if one were to think of the cohort of patients who have low-prevalence mental health disorders.

But the government has made an error in its classification of moderate to severe mental illness. This error has ended up in the funding which would be utilised for people presenting with high-prevalence disorders such as depression and anxiety in the moderate to severe range being transferred to this new program of persistent and severe mental illness. Two to 2½ EFT is not sufficient to provide care for those numbers of patients. So I concur on this and many other points with Professor Littlefield.

Senator MOORE: If I could jump in here for a moment, that degree of detail is not in your submission. Do I take it that on the point you are wanting to make you are concurring with the AMA submission?

Mr Cichello: The AMA and the APS on that point, correct.

Senator MOORE: You did not go into that degree of detail.

Mr Cichello: I apologise, I did not. I ran out of time.

Senator MOORE: That is fine. I was just checking in case I had missed that.

CHAIR: And do you agree with the numbers? The APS is quoting a figure of 87,000. You all seem to agree that that is the size of the cohort that will be affected.

Mr Cichello: I have not actually analysed the figures myself, but I would take the advice of the APS on that.

Dr Hyde: We also took the advice on that.

Senator ADAMS: You say that members have been recently advised by their local division that 'they are not accepting any further providers on their books and/or have changed to any employment model'. This is to do with employing general psychologists at an uncompetitive salary and that is deterring the involvement of experienced clinical psychologists. Could you give us a few more examples that divisions are actually doing this and employing general psychologists rather than clinical psychologists because of the funding?

Mr Cichello: Can I name them or just refer generally to them?

Senator ADAMS: Refer generally.

CHAIR: Yes, refer generally.

Mr Cichello: One of the metropolitan divisions within Melbourne, for example, announced that it had changed its model of which providers it utilises. It had previously had a very interesting model which contracted suitably qualified and experienced clinical psychologists in the field who were working in the private sector. Under contract, people would accept referrals made from GPs who were part of that program. Bear in mind that GPs are not necessarily members of any division, and that is another flaw in the whole program—they are not necessarily members of a division and cannot necessarily use the ATAPS program because of that. It was a very interesting model in that integrating between the sectors, and certainly from what I heard of the tail end of the RACGP presentation this morning and the APS we believe that methods of integrating between service sectors is efficient and good for the public.

But it moved from that to an employment model but did not actually declare it at the time. What we heard from members was that it was then full of probationary and junior general psychologists who had not undertaken postgraduate training or specialisation in working in evidence based methods with psychiatric disorders, and people could no longer provide services. Not every clinical psychologist really wanted to provide services under the ATAPS model, but some of us actually believe in the principles behind it and were very disappointed that that change occurred. It was based on financial grounds. I heard someone this morning—again, it was one of the speakers from the RACGP—say that it is not uncommon that divisions would frequently run out of funds halfway through the financial year. So if you were to present for treatment of a psychiatric disorder you had inequitable access to evidence based care, depending on the time of the year you developed the disorder and fronted to your GP for referral.

Another example would come from Perth in your home state, Senator, and I embedded this example in my submission as a good example of a local clinical psychologist who was known to be a particular specialist with obsessive compulsive disorder and wished to be available for suitable referrals but was locked out.

Senator ADAMS: Thank you.

Senator FIERRAVANTI-WELLS: In your submission you advocate for the retention of the two-year system. In relation to that post-grad training—the two years and the one year for the doctorate—is that supervised?

Dr Hyde: Yes.

Senator FIERRAVANTI-WELLS: Is that the same type of training as the two-year supervised training element of the general psychologists' course?

Dr Hyde: No, it is a registrar program and it is focussed entirely on mental health. You have to have a clinical psychologist who is endorsed as a clinical psychologist—they do not need to be qualified.

Senator FIERRAVANTI-WELLS: I might put some questions on notice. If I understand correctly, Dr Hyde, are you saying that, given the objections that you have to the grandfathering clauses, the entire training and qualification system for psychologists needs to be overhauled?

Dr Hyde: I think it has been overhauled with the implementation of regulation of the Psychology Board of Australia. That certainly put a foundation under the profession. It set standards that are acceptable to the specialties. But I would like to see a specialist title granted to people who do have the qualifications now to enable referrals and for the public to select people who have the qualifications they want.

Senator FIERRAVANTI-WELLS: Where does that put somebody who is a clinical psychologist who has all this training next to somebody who has had 40 years' experience in the profession? For a person out there in the general public, that is a legitimate question.

Dr Hyde: Yes, I understand that. Certainly, somebody with 40 years' experience would have very good experience in particular areas but they do not have the breadth and depth of training that would enable them to see a fuller picture. They can certainly develop excellent skills, and there are some very good general psychologists out there; I am not saying that there are not. I personally trained firstly as a general psychologist but felt that I did not know so much that I went back to train as a clinical psychologist. I cannot tell you what the difference is. The difference in the knowledge base from what you start your experience with is enormous. It enables you to build in multiple ways which are broader and deeper than they would be without it.

Senator FIERRAVANTI-WELLS: Let's look at it from a mild-to-moderate range. Is there some synergy there? Should they be treated equally in that category?

Dr Hyde: There is certainly a place for people without advanced mental health training to be treating people with mild presentations, with a short number of sessions with a very standardised sort of program that we know will work. But once things get beyond that I think more experience is needed.

Senator FIERRAVANTI-WELLS: I know that this is hypothetical but now that there is international registration, is it time then—I think Senator Brown made the point to me before, in the break—to look at some form of parameter that stops the bickering that has been occurring for years and years. I come at it from this perspective, Dr Hyde, as shadow minister in this area—and for the minister himself and for anybody in government—my objective is to look at what is best for the public and the increasing number of people seeking treatment. We keep hearing about shortages of mental health services but if the profession cannot get its act together, isn't that one of the major starting problems in trying to deal with this? Surely the profession itself should have the maturity to think about some solution. Do you talk to each other?

Dr Hyde: Not a great deal at the moment, unfortunately. I totally agree with you. Our profession is shattered. We need to move forward but we need to move forward based on the evidence and in recognition of people's expertise and qualifications. That has been the difficulty for us. That is why we broke away from the APS.

Mr Cichello: Senator, I would like to comment on two levels. Firstly, there has been an ambivalence within the Australian community since the first specialisation within psychology was articulated in Australia. That was in 1965 when the Australian section of the British Psychological Society, as it then was, created a divisional structure of specialist clinical psychologists. Shortly thereafter, in 1968, the state within which I did my postgraduate training, Western Australia, introduced specialist title registration. Clinical psychology was the first of the specialisations to be recognised following the British example. It has really been a rejection and ambivalence of the concept of specialisation ever since. We usually, as a profession, can straddle and hold the tensions between us but lately there has been a certain cohort of members of profession who have taken it on themselves to declare that this rough behaviour is acceptable. I for one reject it, and thank you for articulating your worry.

Ms Leonard: I was concerned because Dr Hyde did give an incorrect estimate of the number of psychologists registered with the registration board as clinical psychologists who do not have the standard training. That number is actually under 600 of the 4,000 registered with the registration board. At the end of the bridging plan program, which, as I said, was set up by the Commonwealth government in the APS, the absolute maximum that can get through is another 600, but on statistics of the proportion that do get through it will only be half of that.

At the end of the bridging program we might have just under 1,000 of the people, who are endorsed as clinical psychologists, who did not do a standard program, but they have all been evaluated to have achieved equivalent training by different means. I really want that to be understood. Also we should notice that in the applications for bridging plans and so on there were 14,000 for plus-2 trained psychologists who could have applied and only 500

of them did. I think we should remember the silent minority when we are talking about the tensions and the hostilities and so on.

Senator FIERRAVANTI-WELLS: My last question is on the National Mental Health Commission that has been announced as a unit in PM&C. I would like to have your thoughts in relation to that and what do you think, and do you agree with previous evidence that it should be an independent body?

Dr Hyde: Absolutely. It should be an independent body and it should have broad representation. It should aim at developing a vision of service delivery that will guide funding rather than this hodge-podge thing where Peter is robbed to pay Paul and money is shuffled around. I could not make much sense of the budget figures because it seemed like they were giving us more money but then, when you look at it, how is it rolled out, how is it taken away from here, what is actually put in there, who actually spends it? We cannot even see where it is spent half the time. I think we need a plan that guides funding, that looks at the overall need and that develops a funding model that will go along with that overall service plan.

CHAIR: Thank you very much. I think you have a little bit of homework.

Dr Hyde: Yes, I have to get a letter to you. Senator Fierravanti-Wells will let me know if there is anything else she wants.

Senator FIERRAVANTI-WELLS: I might just go through the evidence and put some questions on notice for the witnesses.

AHRENS, Ms Jennifer Gaye, Manager Integrated Primary Mental Health Service, Northeast Health Wangaratta

ORGIAS, Ms Natalie Kim, Program Manager, North-East Victorian Division of General Practice

[12:04]

CHAIR: I understand that you have been given information on parliamentary evidence on the protection of witnesses. We have your submission. It is No. 113. I remind witnesses that evidence should address the terms of reference of the committee and that misleading the committee may constitute a contempt. We ask that witnesses avoid making adverse comment against other parties. Such reflections may prompt us to suspend proceedings. Also, we can decide to take evidence in confidence in camera. If you wish to present any evidence in camera at any stage could you please let us know. I invite you to make an opening statement and then we will ask you some questions.

Ms Ahrens: Thank you for the opportunity to address this inquiry. Our interest is engaging the committee in understanding the particularities of providing primary mental health care in rural areas. Although we are speaking for the north-east Victorian region, what we are saying would be relevant to other rural and remote areas. We will outline three key areas. I will speak to the challenges facing rural mental health care and the benefits of an integrated service model, and Natalie will then speak to the funding threats facing this model.

Firstly, I will talk about our challenges and give some background. Life in the country is great, but we do have some issues in providing primary mental health care. With 96 per cent of psychologists and 90 per cent of psychiatrists working in the metropolitan area, it is no surprise we are a little short of them. The majority of our clinicians are mental health nurses, and mental health nurses work comfortably in all three of the biopsychosocial domains. They are ideally suited to rural mental health care, but they are an ageing and declining workforce and there is no encouragement for more of them to appear. We also endure the floods, droughts and bushfires, the tyranny of distance and associated increased travel and service costs. Our challenge is to provide effective accessible care for the 20 per cent of people in our communities with mental health problems. We know that more than one in 10 GP consultations are for mental health issues and that strong partnerships in mental health care work best. We also know that rural people fear the stigma attached to the use of regular mental health services.

The IPMHS has been designed with this information in mind and gives us the biggest bang for our limited buck. The partnership we have formed between the state's mental health service and the local division of general practice gives both state and federal funding to provide across-the-lifespan care via mental health clinicians in 30 regional general practices. Having commenced in 2003, we have a strong track record of initiatives recognised for quality outcomes. Our program has been recognised in the Victorian Public Healthcare Awards, our perinatal mental health service has been used as a model for the state of Victoria and our dual diagnosis service is internationally recognised.

Strengths of the IPMHS include a flexible and supportive workplace, smart use of very limited psychiatrist time and the benefits of a multidisciplinary team both in clinical support and ensuring quality care. The service has built mental health literacy throughout the region, engaging more than 2,000 community members, and three to seven clinicians have provided assessment and care for more than 7,500 clients since June 2003. Health outcome measures have demonstrated statistically significant improvements in patient symptoms and there are high levels of staff, client and GP satisfaction with the service.

Ms Orgias: I would like to highlight some issues around the threats to the service brought about by funding and security. The division is funded by the Department of Health and Ageing under the ATAPS program and the Mental Health Services in Rural and Remote Areas Program. The services for these programs are delivered by the Integrated Primary Mental Health Service in partnership with Northeast Health Wangaratta. I am exceptionally grateful to the Commonwealth for their continued commitment to mental health and the funding that has been provided through both of these programs. As Jenny noted, with this funding we have been able to reach over 7½ thousand people. There are, however, some issues with the way in which the funding is rolled out that creates difficulties in delivering this valuable service. Firstly, some programs, notably the ATAPS program is funded in a 12-month cycle. There are many impacts this has on service delivery.

Clinicians have very little job security, which leaves them feeling undervalued and constantly on the lookout for more secure or permanent positions as the funding period draws to a close. Additionally, attracting new

graduates to the service in an area of an ageing workforce is difficult when only a 12-month contract can be offered. The service is put at risk by continuing clinicians' contracts past the funding period. This is done to avoid disrupting services to patients and disillusioning referring GPs, but it is obviously undesirable. In contrast, the rural and remote program has just been refunded for a further two years to June 2013. The extension funding for a further two years provides a degree of security for this service, which is particularly valuable in light of the change to the primary care environment, including Medicare Locals. There appears to be little consistency in the contract time frames in various areas of the department.

Secondly, there is the late notification of the continuation of funding for the programs and of the funding level that will be provided. This again impacts on the continuity of service and the retention of clinicians as well as future service planning. Just to give you a couple of examples regarding the ATAPS program, the final letter of offer and deed of variation were not received until 16 June. The previous contract finished on 30 June. So we had two short weeks for planning and recruitment. Likewise, for the rural and remote program, the documents were not received until 27 June—three days before the previous contract expired.

CHAIR: At least you got yours before the contract expired.

Ms Orgias: True. We were very lucky in that regard.

CHAIR: I say that because I have heard of other organisations who get it afterwards.

Ms Orgias: Yes. Having said that, we are very grateful again for the two-year funding for that program. Thirdly, there is the lack of funding increases in line with service provision costs. This has been a continuous issue for this service. For the last five years, base funding to the ATAPS program for tier 1 services has remained constant, with no consideration of increases in clinician wages or increased travel costs relating to fuel price increases. This has been highlighted to the department repeatedly as an issue for this service in annual plans and reports. The increase in wages for clinicians and associated service provision costs has meant a 15 per cent reduction in clinician hours for this coming financial year. This is in stark contrast with the state funding for the area mental health services, which is recurrent and indexed. Recurrent and indexed funding from the Commonwealth for all of its mental health programs would provide service security and stability for clients, clinicians and GPs and would enable innovative services, like the integrated service, to continue to assist the many people with mental health issues.

Another area of concern is the budget announcement in May that indicated a reduction in the payment to be made to GPs for the development of a mental health treatment plan. New time based items will commence in November and will reduce support to GPs in the pivotal role that they play in the mental health of their patients. It is hoped that this work that GPs do regarding mental health will always be appropriately financially rewarded.

Ms Ahrens: In summary, we would endorse a Commonwealth funding arrangement for primary mental health care that addresses the concerns highlighted in the submission—that is, funding that is recurrent and indexed. This would enhance recruitment and retention of staff, particularly in rural areas where it is so difficult to get experienced clinicians. We would also welcome the opportunity for the IPMHS to be evaluated as a potential model for rural primary mental health care delivery.

Senator FIERRAVANTI-WELLS: Could you just go back on those figures. Did you say 90 per cent of psychologists and 95 per cent of psychiatrists?

Ms Orgias: I said 96 per cent of psychologists and 90 per cent of psychiatrists. These are the mental health workforce figures—mental health nurses, psychiatrists and psychologists.

Senator FIERRAVANTI-WELLS: Is that roughly reflected in your area?

Ms Ahrens: Yes. We get four hours of psychiatrist's time for our team, so we have to be very smart about how we use it.

Senator FIERRAVANTI-WELLS: On the ground, how do you think these changes to Better Access are going to affect your area?

Ms Ahrens: Better Access is not that widely used because we do not have a lot of people who are funded under Better Access in terms of clinical psychologists et cetera. ATAPS is a far more important program for us in the country—and it is free. Because of the extra cost, often a GP will refer to a Better Access, and then the client will say, 'I can't go—I can't afford the gap.' They also like being seen in the general practice.

Senator FIERRAVANTI-WELLS: You say in your submission that up to 60 percent of people attending primary care clinics have a diagnosed mental disorder. Is that based on your—

Ms Ahrens: No; they are general figures for the area. But it carries pretty much across Australia that way.

Senator FIERRAVANTI-WELLS: Tell me about your area—what is the spectrum of people in terms of Northeast Health and Wangaratta?

Ms Ahrens: We have a large disadvantaged population in the Benalla and Wodonga areas. We have a lot of rural areas where there is a lot of farming communities who have been badly affected by drought, and there are some bigger rural towns such as an Benalla, Wangaratta and Mansfield. So it is a mix of farming, tourism and some very disadvantaged areas.

Senator FIERRAVANTI-WELLS: How do you deal with the cross-border issue?

Ms Ahrens: The cross-border issue is a nightmare.

Senator FIERRAVANTI-WELLS: I knew this would elicit this—

Ms Ahrens: Yes. At this stage, it is not an issue for primary mental health care, because our local division is solely located in Victoria. For the mental health services, we are taking on more of the Albury services. Under the new Medicare Locals, we will be expanding out into the back blocks of New South Wales. What seems to happen is that, as Victoria takes over New South Wales services, they withdraw any services they have. So Victoria is going to cop a lot of—

Senator FIERRAVANTI-WELLS: When I was last down there, I went to see private mental health facility, and they were saying precisely that. They were very positive about the Victorian services, but they said the encroachment was having other effects. The Victorian border services were needing to go quite long distances—from the Victorian border to places like Wagga is quite a distance.

Ms Ahrens: Exactly—and in our local division we already have about 33,000 square kilometres. When you have very few service providers, it is a really difficult thing to attract people to work in the service who have the skills and are not too far away from those areas. As Medicare Locals makes our division larger, that is going to be more an issue.

Senator FIERRAVANTI-WELLS: Can you tell me more about services in your area provided by social workers and occupational therapists?

Ms Ahrens: Yes. In the general mental health service, social workers and occupational therapists are employed, and they are very much doing the work that they should be doing, which is their various specialties. In our team we do not have any occupational therapists—they are not very thick on the ground there either—but we do have a social worker, who works as a clinician in the team.

Senator FIERRAVANTI-WELLS: So you have both general psychologists and clinical psychologists working with you?

Ms Ahrens: In the team we have a general psychologist, and the rest are mental health nurses.

Ms Orgias: Just on that note—we received a letter from the peak body of the social workers reminding us that ATAPS can employ social workers. We have only had ever had one application from a social worker—who we ended up employing—any time we have advertised positions for the team. So they are not out there.

CHAIR: People do not want to be out there in the bush.

Senator FIERRAVANTI-WELLS: No.

Senator MOORE: Most of it has been covered. Did your service give evidence to one of our previous mental health—

Ms Ahrens: Yes, and Senator Siewert was there too.

Senator MOORE: Yes, I thought I recognised you; I do remember that. It is interesting to see that contrast. I did not have time to root out your last submissions, but I thought I recognised the process. In terms of youth services, how far away is the closest specialist youth service or headspace?

Ms Ahrens: Melbourne.

Senator MOORE: So Melbourne has the most direct service particularly for youth. We talked about that at the last hearing where you talked about the range of things. Are there particular issues for youth mental health in your area?

Ms Ahrens: Yes. We do not have bulk-billing GPs.

Senator MOORE: You did not last time either.

Ms Ahrens: No. We have CAMHS—child and adolescent mental health—but my personal belief is that youth services have to be out there, not in a mental health service. They have to be in the CBD, somewhere where it is attractive for youth to come.

Senator MOORE: And safe.

Ms Ahrens: And safe. They have to incorporate a lot of things besides mental health. You cannot just set up a mental health service on the corner and expect someone will come, because they will not. But if you have got sexual health and, say, headspace type models, that is great.

Senator MOORE: Senator Fierravanti-Wells covered a lot of the workforce issues I was concerned about. It seems that your model, the one that you are quite keen to promote because of the interaction, has that link with nurses, which is core to the whole process.

Ms Ahrens: Absolutely.

Senator MOORE: Have you presented your model to the minister?

Ms Ahrens: No.

Senator MOORE: In terms of the way yours works—and it is peculiar to how you have made it work in your area—there would actually be a similar need in other places. You do not have too many GPs. You only have one psychologist. You have a social worker when you can get one through ATAPS and you actually use the services that you have there.

Ms Orgias, you talked about your concerns about the GP process. How do you see that impacting in your area? In your verbal submission you actually said that you were a bit concerned about the change in the GP process.

Ms Orgias: Both of these programs that are funded by the department, ATAPS and the rural and remote, require a GP management plan to be developed. We sometimes have difficulty getting management plans with a referral for these programs.

Senator MOORE: Now?

Ms Orgias: Yes, and we are thinking that there is less financial incentive to do them so it might be an even greater struggle.

Senator MOORE: So with the interaction with the GP, you are having trouble now, before there are any changes?

Ms Orgias: Yes. They need some encouragement.

Senator MOORE: So with your service, which has got the multidisciplinary team without a lot of disciplines working, what is the interaction with the GPs who are doing those plans with your service now?

Ms Orgias: The interaction between the GP and the clinician is fantastic. The clinician is based in the GP practice. The GP makes the referral, the clinician has access to the patient notes, and the clinician can put their own notes into the patient's file so that the GP always has up-to-date information. So the feedback loop is terrific with this model.

Senator MOORE: And we have seen that happen a fair bit since there has been more funding, that you have a GP and another person in the same practice so people have that kind of community process.

Ms Orgias: It works very well.

Senator MOORE: And that is the way you prefer to operate?

Ms Orgias: It is not only good in that it is giving up-to-the-minute feedback to the GP, but it also provides opportunity for the corridor consultation and the secondary consultation. Just being there, knowing the person they are referring to gives them confidence to refer, and knowing that they are going to get feedback and a report is very encouraging, rather than sending off to someone under better access that they may or may not get a report back from.

Ms Ahrens: They also get contact with a psychiatrist through the clinician, which is valuable, because psychiatrists are as scarce as hens' teeth.

Senator MOORE: Would that be the visiting psychiatrist?

Ms Ahrens: Yes. As part of the team, we have a psychiatrist.

Senator MOORE: Does that come out of the state?

Ms Ahrens: Yes.

Senator ADAMS: I would like to move on to technology. Do you use teleconferencing or videoconferencing with your team for your more remote patients?

Ms Ahrens: No. We actually have the clinicians in all the areas, so we do not need to.

Ms Orgias: We did participate in the ATAPS telephone CBT trial. However, there were no referrals from the GP. When it was opened up to allow the clinician to recommend a patient for telephone CBT nobody saw the need to, because we have them in the practice. It was tried on a couple of occasions. A clinician had to set up a time and ring the patient. For a patient who happened to be out on his tractor on the farm at the time and could not hear, speak or be committed to the process, it just did not work.

Senator ADAMS: I am really interested in the Medicare Local and how the division is going to manage the changeover. Could you give us a bit of an idea of how the divisions within your area are coping with it?

Ms Orgias: As you know, the information that has come out about Medicare Locals has been a bit piecemeal. We are always playing catch-up to some extent. We are merging with our neighbouring division, with which we have a really good relationship. The program managers from each of the divisions are already meeting to talk about their programs. We have not yet been signed up as a Medicare Local; we are hoping that will happen shortly. We are anticipating that programs will continue as they are for the next 12 to 18 months, with a possible review after that stage to see what works best and to utilise what works best from each area, and whether we spread it across or we keep it within the models that are working at the moment. So it is really a wait-and-see situation. It is very new for all of us.

Senator ADAMS: The part that really worries me is whether the dollars actually get to the service delivery. A lot of the divisions are fairly big areas.

Ms Orgias: Yes, ours is.

Senator ADAMS: I come from rural Western Australia, so I really understand; I know the area you are in. It does concern me—and has all along—that this Medicare Local is going to be three, four or five times the size of the divisions that were there and how that is actually physically going to get on the ground. It sounds like your team is actually getting to the right people, but I am quite concerned about other areas.

Ms Orgias: I think we probably have a head start, because the north-east Victorian division was always one of the larger divisions. We have probably increased our size by only about a third, so we are probably going to be able to take it in stride.

Senator ADAMS: Another comment that has come up today is the fact that often general psychologists are employed before clinical psychologists. I imagine that in the area you are in you would be very grateful to get anyone who was prepared to put their hand up, whether they were a clinical psychologist or a general psychologist. Could you comment on that?

Ms Orgias: We would take anybody!

Senator MOORE: That is now on *Hansard*!

Ms Ahrens: Coming from a rural area, I think there are specific disorders—for example, obsessive-compulsive disorder—for which there really needs to be someone who is very expert in that area to provide treatment. I think that if you compared the health outcomes of our clients with the health outcomes of any other ATAPS program we would compare favourably. We are mental health nurses, with a psychologist and a social worker. Given the work we are doing, I think we are doing it admirably.

CHAIR: I would like to follow up on the technology issue and talk about the online services that are starting to be funded. Do you think they are useful? Will they help in rural, regional and remote areas?

Ms Ahrens: To some extent. Some of the websites are fantastic, though we do have so many people coming now and saying, 'I have got bipolar disorder because I went on the Black Dog website,' and you have to spend an hour with them convincing them that they do not. So they are a mixed blessing. But, certainly, things like MoodGYM—that is the program that a client can do at home with support from a clinician—is an excellent program. We often do not have fast internet, so we cannot use them anyway.

CHAIR: We are not going to the NBN before anybody else starts; let's not go there. Have you been involved in any consultation about how online services could be delivered, particularly to regional and remote communities?

Ms Ahrens: No.

CHAIR: I will follow that up with some of the other witnesses who are involved in providing some of the online services and see how they are consulting with communities. I want to go back to this issue of Better Access, about which we have heard a lot of evidence this morning. It seems to me that you are not so concerned about Better Access—

Ms Ahrens: No

CHAIR: because it is just not available for regional and remote communities.

Ms Ahrens: There is some available. It is great for when our clinicians are on leave—that the doctor has got a choice—but for most of our clients it is not a huge option. It is there, but there are not a lot of people registered.

Ms Orgias: The division maintains a register of the clinicians in the area who are registered for better access. In our region, which bleeds out to Albury-Wodonga, there would not be more than 40 on our register.

Senator MOORE: We have heard evidence about ATAPS money running out. We would like to pursue whether that happens. First of all, if your money runs out—

Ms Orgias: It does not.

Senator MOORE: You have got yours; it does not run out.

Ms Orgias: We budget ours and because it is an employment model we employ the EFT that we can with that funding. I have heard of other divisions where their money has run out three months into the year. Because we have an employment model it is balanced across the year. It means that there is less during the year but it is spread.

Ms Ahrens: It works quite well except for the fact it is not indexed. Even though some of our clinicians' wages might go up 5 to 10 per cent a year, we have not had a cent.

Senator MOORE: Which was the general point you made in your submission.

CHAIR: And it is not an unknown issue that we come across in this community.

Senator MOORE: No. We have heard of it happening from time to time! Can you give us some more information about how you budget your ATAPS? You can put that on notice. You must have something that you do. Tell us how you work it out, how you get your budget and what you do as an organisation? It would be useful to have that for our evidence.

Ms Orgias: You would like something in writing?

Senator MOORE: Yes.

Ms Orgias: I can do that.

CHAIR: As a corollary to that—when you say you do not run out because you budget it—do you have unmet need in that case?

Ms Orgias: We do. Our current waiting list is about 28 days, which, if you are feeling distressed, is too long. Some of our busier practices may have an eight-week waiting list and we have some single-practice GPs where it takes two weeks before someone can get in. That is what we aim for.

CHAIR: If you can get on a GP's list. If you are in the bush, getting on a list is—

Ms Ahrens: And that is the other issue that we need to address. We use some of the state mental health money to see people who will not have a GP, cannot get a GP et cetera. We do a lot of the rural farmers by rural outreach through the state mental health service. It is all part of our model. We would love the opportunity to present it to the minister.

CHAIR: In terms of the 28-day waiting list and the issues around crisis, how do you address the issues around crisis? Is that where you access the state services?

Ms Ahrens: Yes. The beauty of having a partnership between the state mental health service and the Commonwealth with ATAPS is that we have a quick link into the state mental health service, which can be a very difficult thing to negotiate if you are not familiar with the way mental health services run.

Senator SIEWERT: How long did it take you to build that relationship, because you seem to have a better relationship than some other areas?

Ms Orgias: We have been very fortunate; we do have a terrific relationship. In fact, we have organised other programs outside of the Integrated Primary Mental Health Service based on the strength of that relationship. It was set up before my time. I believe it was the relationship with the people there. That relationship has existed because it has been beneficial for both sides, and we have both had the same target and the same goals. We work seamlessly together.

Senator MOORE: You have moved beyond personalities. Often good relationships are based on the individuals who happen to be there, but yours has moved forward so that although individuals come and go the strength of the program is maintained.

Ms Ahrens: Absolutely, because the original manager of the mental health service and program manager from the division have both gone.

CHAIR: Thank you very much. We have given you a little bit of homework, I think. It would be much appreciated if you could give us that information. I very much appreciate the time you have taken specifically to come down to talk to us. Thank you

Proceedings suspended from 12:36 to 13:30

ARMSTRONG, Mr Philip Richard, Chief Executive Officer, Australian Counselling Association

JONES, Dr Clive, Board Member, Australian Counselling Association

CHAIR: I welcome representatives of the Australian Counselling Association. I understand that information on parliamentary privilege and the protection of witnesses and evidence has been given to you. Do you have any comments to make on the capacity in which you are appearing today?

Mr Armstrong: I am here in two capacities. I am the CEO of the Australian Counselling Association. The second capacity is as part of a partnership in a bipartisan private submission.

CHAIR: We have your organisation's submission and your submission as well in front of us.

Dr Jones: I am also involved in presenting the independent bipartisan submission and am also a board member of ACA.

CHAIR: The committee reminds witnesses that evidence should address the terms of reference of the committee and that misleading the committee may constitute a contempt. We ask that witnesses avoid making adverse comments against other parties and that such reflections may prompt the committee to suspend proceedings. We can also decide to take evidence in camera. You can also request to give evidence in camera if you so desire during the proceedings. I invite you to make an opening statement and then we will ask you some questions.

Mr Armstrong: We thank the committee. We certainly appreciate the honour of being able to meet with you and answer any questions on our submissions. We thank you for taking our submission seriously enough to invite us to be here. First of all, from the submissions I have read and heard today there are common themes running through the issues to do with mental health. I hear people talk about standards. As the CEO of ACA, I am sure the APS, the AASW and all the other professional bodies can put forward a very solid case that is based on efficacy and research as to the standards of their members. One point that has been missed in that is that in Australia we have a highly qualified and well experienced workforce. Mental health is experienced along a continuum. The delivery of mental health services should be delivered along that continuum and that continuum should not be broken up into silos of badges of professions. It should be delivered by people who are appropriately trained and experienced to deliver at the level that the mental health people need.

Dr Jones: I would also like to thank everyone here for offering us this opportunity to share our thoughts and to elaborate a little further on what we have written and presented. To put it in a nutshell at the very beginning, the next step forward in terms of qualitative reform in mental health is a collaborative approach, where we work together across the subdisciplines of mental health in order to offer a better service to the community. If we can achieve that, we will all be winners.

Senator FIERRAVANTI-WELLS: Can you tell me a little bit about your organisation? Do you represent bodies or individuals? Where do you fit into the picture with everybody else? It is a pertinent question in this inquiry. And who do you agree with and who do you disagree with?

Mr Armstrong: Where do we fit? We agree that there is a continuum of mental health requirements for the Australian public—

Senator FIERRAVANTI-WELLS: We all agree on that.

Mr Armstrong: and we agree that the mental health consumer should have services delivered from an equitable perspective in that the people delivering that service should not be based on whether they register with a certain body or wear a professional badge but that they be qualified to be delivering the service at the level that the consumer requires.

Dr Jones: In one sense we would agree with the fact that every subcategory of mental health speciality does offer quality in service and in that sense we would agree with anyone within those subcategories of mental health who say that they can offer a constructive service. We would agree with that. What we are concerned about is when there is unnecessary bickering as to who may be better.

Mr Armstrong: The Australian Counselling Association is a professional peak body incorporated under the Associations Act. We are owned and run by the members of the association. We represent approximately 3,000 counsellors nationally throughout Australia. We have significant recognition overseas throughout Asia, America, Canada and the UK.

Like most peak bodies, primarily we act as a registration body. We register counsellors through a vigourous registration process that is based on qualifications, experience, professional supervised practice—all the normal things as you would expect from a peak body. We have mandatory requirements of professional supervision for our practitioners; we have mandatory requirements of professional development for our members. These are all requirements that must be met on an annual basis.

Last year we passed the auditing process for Medibank Private legislative requirements for private health provider numbers for our members. The reason I mention that is that that is a significant auditing process. Passing that auditing process signifies that we do have the appropriate systems in place for members as well as personal files, annual requirements and a professionally staffed office. We are growing annually. My job as the CEO of ACA is to represent those 3,000 counsellors who operate within the mental health system.

Senator FIERRAVANTI-WELLS: So you are not one of the groups under the national registration umbrella. Do you think that eventually your counsellors will come under that umbrella?

Mr Armstrong: I suppose it is a point of whether that is the requirement. The requirement for registered counsellors in Australia right now has been identified as being quite appropriate. So far we have had no indication from government that there is a requirement, a need or desire to regulate us simply on the basis that we self-regulate at a very high level. As I said, I am here to represent registered counsellors. Obviously I cannot speak for non-registered counsellors; I can only speak for our members.

Senator FIERRAVANTI-WELLS: Dr Jones, from what you said before, in effect did your comments mean that everybody is free to put up a shingle and do certain things?

Dr Jones: No, not at all.

Senator FIERRAVANTI-WELLS: Could you just elaborate on that—maybe I did not quite understand what you were saying?

Dr Jones: We are very fortunate in Australia to have a very high quality education system and as a consequence of that the knowledge base of training across various disciplines of psychology, social work, counselling, mental health nursing and so forth. Anyone who is wanting to develop skills in the practice of psychotherapeutic treatment for mental health care actually all have the opportunity to develop the skills to do so effectively. That is a direct consequence of a freedom of knowledge and a capacity to obtain the right training. Within academia there is often a cross-pollination of specialists in various areas of training as well. You can have psychologists and social workers and counsellors training counsellors. While I am not a clinical psychologist—I am counselling psychologist and a sport and exercise psychologist finish—I have offered practice placements and have had clinical psychology students in my practice. So on the ground in many ways there is a lot of cross-pollination of disciplines, skills and knowledge that really is funnelled into effective psychotherapeutic practice.

Senator FIERRAVANTI-WELLS: Tell me about the Better Access changes in relation to your sector and how it is going to directly have an effect.

Mr Armstrong: . It has no effect on our members because we do not get access to it in the first place.

Senator FIERRAVANTI-WELLS: That is what I was thinking. But you have obviously got some views on it.

Mr Armstrong: We believe we should have.

Senator FIERRAVANTI-WELLS: You believe the Medicare rebate should extend to counselling.

Mr Armstrong: I think particularly our level 3 and 4 members certainly meet the criteria for the Better Access. Also, we believe that we certainly meet the criteria for ATAPS. We are talking about two differently qualified counsellors. There is absolutely no reason why they should not have access to it. However, that sort of detracts a little bit from the perspective we are coming from in that we believe that mental health is in a continuum, and that is the issue which we discuss in our private submission. The problem is the siloing of professions. Every profession wants the dollar for their profession and every peak body wants the money for their members—which is fine. I do not have an issue with that; it is what they are there for. But the problem with that is: who does government then put the money to? Who does it listen to? Those with powerful lobby groups? What about those who are disenfranchised because they do not have powerful lobby groups? Shouldn't it be based on consumer need? The consumer need is best looked after by ensuring that the person whom they are seeing is at the appropriate level—not over qualified or underqualified.

Currently, we have a system in which a lot of people would seem overqualified or where the consumer is being overserviced. This is not because there is a problem with the training or the qualification of those delivering the service but because the consumer does not get access to the choice of person at the appropriate level they need. If

you look at our continuum, we talk about social support, then we talk about mental health problems and then we talk about mental health illness. That is a continuum. There is an overlapping of qualifications and there is an overlapping of professional experience in the delivery all along that continuum. Right now we have siloed. Primarily, a lot are at the top end. The fact is that the majority of Australians do not suffer from a mental disorder. Those who have a mental illness of some sort suffer from a mental health problem. Therefore, shouldn't we put in place appropriate delivery systems that deliver the appropriate services for those people? Currently, from my perspective anyway, I do not feel the system does that, because there is too much of this professional—

Senator FIERRAVANTI-WELLS: Mr Armstrong, do I understand that you are saying that, at one end of the spectrum, counsellors should be providing a service at the mild end of the spectrum?

Mr Armstrong: No, definitely not.

Senator FIERRAVANTI-WELLS: Sorry. If you could elaborate what you mean.

Mr Armstrong: We have four levels of membership. We have members who are currently working in clinical mental health, working with people with significant psychological disorders such as schizophrenia. We also have members who are working with people with mental health problems down at the lower end. Our members work through the entire continuum from social support right through to the clinical end, which is why we have the four levels of membership. It depends entirely on their experience, their qualification and their ability to deliver at that level. They are employed through government. They are also employed through NGOs. And we have members in private practice. So, again, our members fit throughout that continuum.

Senator FIERRAVANTI-WELLS: You talked about getting on and finding solutions. What is your view on a national mental health commission?

Dr Jones: A commission to?

Senator FIERRAVANTI-WELLS: One of the terms of reference is a national mental health commission. What is your view on what that should be?

Dr Jones: In that context, what we are proposing here is a national register of mental health practitioners, which is one way to encourage and facilitate collaboration and cooperation between mental health providers who are already trained and providing mental health care. On the ground there are a number of people who are already trained and who are already effectively offering mental health treatment and care. So we are proposing a commission that encourages that process of collaboration and cooperation between the disciplines—for example, social work, counselling, psychology, mental health nursing and the broader spectrum of mental health carers. That would be the essence of what is required. We have an untapped workforce that can offer a lot to the community and already are. The level and degree of service that is being provided across those disciplines is very effective and authentic. When you look at it ideographically in research, anecdotally through individual cases on practice and when you look at it empirically through research it shows over and over again across all of those disciplines that they are providing effective mental health care. Being able to tap into that and provide a system that is able to tap into that and accommodate those specialists is what is needed.

Senator FIERRAVANTI-WELLS: There are a couple of points you make at the end of your submission. You say that the governments and the mental health professional sector move towards a single national registration. Are you saying that about the national registration framework under the new arrangements? Is that what you are saying?

Dr Jones: At the end of the written submission is the recommendation for a national register of mental health practitioners. In terms of how that ends up being set up is something that can be collaborated and decided upon in the context of those professions that would a part of it. It could be the legislated registration or in some other form.

Senator FIERRAVANTI-WELLS: In your next point you say, 'Any registered mental health practitioner with expertise most directly relevant to the client's circumstances should be able to take a GP's referral under Better Access and ATAPS.'

Dr Jones: In that context there needs to be an understanding of that continuum of need. Also, where the continuum of need is matched with the type of training, the training is far less to do with the badge of psychology. I mean that respectfully in the context of all sub disciplines of mental health in that the name or the title that they are given as a psychologist, social worker, counsellor or mental health nurse is to do with the training to work in the area of social support, psychotherapeutic aid or psychotherapeutic treatment. All areas of training have the potential and the capacity. Many do offer training across that continuum in terms of practice placements and the actual knowledge base that they are being taught.

Senator FIERRAVANTI-WELLS: Do I take it from the next point in your conclusions that, in other words, in creating a next level down of access you are putting it in the context of affordable costs.

Dr Jones: Yes.

Senator FIERRAVANTI-WELLS: I do not quite understand that. Are you talking about a cheaper service where there is nothing else there? I do not quite understand what you mean by that. Could you just elaborate? You have made the point at the end of your submission that mental health funding programs include appropriately qualified and registered counsellors and other non-psychologist mental health professionals to ensure that skills and expertise most relevant to a client's needs are available at affordable cost to those clients.

Mr Armstrong: It does sort of tend to move back to my issue right now that there is not equity over access and delivery over that continuum but we have over servicing. At some points in our system we have heart surgeons putting on bandaids, which is not very cost-effective way of delivering any service.

Senator FIERRAVANTI-WELLS: Give me a practical example, please, Mr Armstrong.

Mr Armstrong: I can tell you of numerous examples. I am a clinical director of my clinic. I have social workers, psychologists and counsellors working throughout that clinic. We have a mental health worker who bulk bills. We have a psychologist who does billing through the Better Access with a gap payment. We have counsellors who are full-fee paying because they do not get access to anything unless the client has a private provider. People ring up with an issue such as workplace bullying. They are starting to not sleep at night and it is starting to concern them. It is not impacting on them immediately in any direct link. It is early stages and they want to get help. They want to get something through the system. They do not have any money so they cannot afford a private service, so the counsellor is automatically ruled out. A counsellor could very well and easily deal with that issue. We then explain to them how Better Access works and how the health care plans work. So they go off to the GP. The GPs is in the area where I have my practice have a preference to first-referral certified clinical psychologists. They then do a referral to the clinical psychologist. We get a fax from mental health care, the plan comes through the practice fax machine, the clinical psychologist gets the referral and the client then comes along and sees the clinical psychologist.

The system is paying a fortune for that. First of all, they are paying the GP for the mental health care plan, which I have no issues with—we need someone to be able to gate keep. But we have a clinical psychologist who is charging top tier to see somebody who could very easily be seeing a counsellor on second tier, who would quite possibly also bulk-bill. That is overservicing. The issue is that the GPs have a preference because they believe—

Senator FIERRAVANTI-WELLS: The practice nurse-equivalent in a—

Mr Armstrong: I don't know I could say we are equivalent to nurses but the—

Senator FIERRAVANTI-WELLS: No, the concept of the—

Mr Armstrong: Yes, pretty much, and that is where it is costing the system a lot of money. We have three GPs in the immediate area of my practice and I know this is very commonplace throughout our members which—as I have said, it is the national body we have—has happened since 2006, since BAI came in, and a lot of GPs do have a preference to go to top-tier services. The problem there is the clinical psychologist, the one down the road from my practice, has closed his books. He is not taking any more referrals. So we then go down to the general psychologists who have waiting lists of up to four weeks. The mental health worker who is bulk-billing has more work than she can poke a stick at. We also have three tertiary qualified counsellors sitting on their bums twiddling their fingers, because there is no work coming through, and my clinic is in a middle-class area. This is not a low socio-economic area.

The reports we get from low socio-economic areas in Brisbane like Logan City are just tragic, but even in a middle-class area such as where my clinic is people do not have money to pay for full fee-paying services and they struggle for gap payments as well. We also have a significant workforce out there—not just counsellors—of appropriately qualified people who are waiting, who are qualified, who are experienced, who are able and who are capable of delivering services at the appropriate level, but because they do not have this badge on their forehead they do not get access to it.

Senator MOORE: The same issues.

Mr Armstrong: Always. We will not go away.

Senator MOORE: I think it is really important to keep the discussion going but what I would like to hear from you and Dr Jones is what support you have with other medical professions and groups within the areas. Is there openness to what you are discussing? Is there mixed response? You have been raising these issues for many years now.

Dr Jones: In terms of mental health care and a collaborative approach, there has been some excitement over it, in my involvement, with the Australian psych society and a couple of their colleges. I would have to say that bodies at the moment are just taking care, in context of the committees hearing and so forth. There is generally a sense of, yes, collaboration does need to occur and they are looking forward to a method and a way to make it happen.

Mr Armstrong: Off the record there is a lot of support. Obviously this submission is relatively new. We have not had time to start any roundtable discussions with other peak bodies. Most of the peak bodies have received a copy of our private submission and I have received a lot of phone calls and emails off the record supporting it, thinking that it is a great idea and should happen. The problem is, trying to get people to put on the record is very difficult.

Dr Jones: They have not really started doing that. In respect to the committee hearing, we wanted to put it forward here, formally, first.

Senator MOORE: And your concept of the roundtable?

Mr Armstrong: It would be getting all the peak bodies together with representation from consumer groups, carer groups and a lot of other groups that may not usually be involved—say, more than just the peak bodies but a roundtable—to look at setting up some sort of registration body that can set out the standards for delivering at the appropriate level. As I said, it would certainly have to involve a lot of consumer groups and carer groups, because I think that would bring a lot of balance and help to bring a lot of the peak bodies and professions together, as opposed to continually trying to silo. There are reasons why the professions do that, but it needs to stop if we want to do what we are here to do, and that is to look after the mental health consumer and the Australian public, not ourselves.

Dr Jones: Again, I just talk about it anecdotally from my own experience. That is not putting away the concept of empirical evidence as well. You are looking at NGO organisations that employ psychologists, social workers and counsellors and where they are working effectively together in providing quite significant and intense mental health treatment and care. When you see it working on the ground really effectively it is clear evidence. They are wonderful case examples of the fact that it can be approached and embraced at a broader, large-scale level—that collaborative approach of mental health care across disciplines. It works really well.

Senator MOORE: In regional health services and in PHaMs centres, you have a cross-grouping.

Dr Jones: Yes. Even in private NGOs.

Senator MOORE: The defining point is access to government money and the Medicare rebate.

Dr Jones: It is not about the money. For me, sometimes it is just a palm tree—sitting under that is good enough! It is about trying to work a system that offers the best form of mental health care. We already have quality education in place; we already have quality practitioners in place across a spectrum of subdisciplines that are already offering a lot of care. It is about offering a greater opportunity to harness that and allow the best opportunities for those already trained, skilled and equipped and doing it in whatever way. Often it is about qualitative reform rather than quantitative reform. It is not necessarily about throwing more into the bucket; it is often about just reshaping the bucket.

Senator MOORE: I think it is the society's submission and not to your private one that goes into detail about the qualification levels. Could we get some more information from you about the tertiary institutions that provide the training that qualifies people—I know you have this; where people can access their qualifications—and also some information about the cost scales for counsellors with various qualifications that you have within your organisation, the costings that you have to charge to make a living? The costings scales would be very useful.

Mr Armstrong: ACA has an accreditation standard that the universities must meet. We do not automatically accept university courses because we believe there are university courses out there delivering courses that do not meet our standards. However, we work along the Australian Qualifications Framework system and we only accept accredited courses. If any training provider puts out a non-accredited course, we will not accept their qualification. Here in Victoria it is La Trobe University. La Trobe have quite a significant program for training of counselling practitioners at the tertiary level, as does the Victoria University.

Senator MOORE: I know you have that all in your organisation. Could we get that on notice? If you could send that to us, that would be useful. We talked about it before, but it would be nice to get that updated, as well as the costings. That would be useful.

Mr Armstrong: Regarding the costings, there are not many counsellors making a living currently, except those who are employed. The ones in private practice are generally charging anything from about $75 an hour,

depending on their qualification, up to $120. We have counsellors with a PhD and they struggle to get $120. Australians just cannot afford it. I keep coming back to that. I do not know where people get the information from that we are a wealthy country. People out there cannot afford it, and $120 would be at the top of the scale and that would be in Sydney. You would probably not get that in Brisbane. In Melbourne you possibly could. When you start getting to regional areas, the counsellors are almost giving it away, at $50 and $60, and the regional areas are even worse off. People will go to counsellors in regional areas primarily because there is a lack of other services there.

Some regional areas do have good NGOs but a lot of counsellors are employed under administrative award rates. They are certainly underpaid compared to other health professions. There was a new health award rate brought out recently. We are now educating councils and employers that it is the award they should be paying counsellors under. That is now bringing the employment of counsellors back up to a more reasonable level. That is pretty much as far as the rates go: you can go anything from $50 or $60 an hour in a regional or isolated area to $75 to $120 in the cities.

Senator MOORE: And that has no reference to qualifications. That has reference to availability of work.

Mr Armstrong: Yes, pretty much. We do not dictate to members, depending on their qualification, how much they should charge. We cannot enforce it.

Senator ADAMS: In your main submission, not the private one, you talk about how you intend to continue to build up good relations with general practice and then the transition to Medicare Locals. Would you like to tell me where you are at with that and where you expect to go and how you think it is all going to work?

Mr Armstrong: In the past we have had reasonable relationships with some divisions of GPs. In Queensland we did get funding from the state government for around four to five years where we were delivering counselling services with full government rebates within regional Queensland. That was generally through the GPs. Again, the GPs were doing the referrals. That was during the drought and we went from a drought to a flood. That funding actually stopped last year and so we were working with the division of GPs within Queensland through that area. We have spoken to some other divisions, but we have not developed a close relationship. With this submission and the model that we are looking at, we are starting from the beginning again on that. So we are yet to formally go to the primary divisions and talk to them, but we have spoken to individual members within the divisions and had a very good response from them.

Senator ADAMS: I have just a suggestion, if I may be so bold. With the Medicare Locals starting up, and the 15 that have already been approved, it might really pay to get in on the ground floor and be right there, because it is all about primary health—that is what they are about—and make sure that the dollars do actually track back to people. That is my main concern. I do not want to see them taken up by administration. It is about the people on the ground getting the service. Looking at your list in your private submission of the number of organisations you want to get together in a roundtable, it is a multidisciplinary team. That is the way primary health is going in the future, so I think you are right there to actually do something. That was not really a question.

CHAIR: I want to go back to the idea of the register. Senator Moore was asking you about linking it to funding. I appreciate the comment you made that it is not about funding, but would you see that the process of being on the register would then facilitate easier or greater access to funding once you are on the register and accredited for providing certain services?

Dr Jones: I think in the sense of the goal being a national plan and a national strategy it is how the funding is distributed in that context, not necessarily whether there is more or less. That is the important thing. I suppose it is just strategic use.

Mr Armstrong: Are you asking about access for the consumer?

CHAIR: I am asking, for example, in terms of services that are not currently able to access funding that could then be funded.

Mr Armstrong: With the appropriate—

CHAIR: With the appropriate safeguards.

Mr Armstrong: Yes.

CHAIR: I want to go back to the comment you made around GPs referring to clinical psychologists rather than more appropriate levels. Have you spoken to any of the GPs or the divisions about that?

Mr Armstrong: Again, this is a very sensitive issue. I have had private conversations with people in significant positions within the GPs, and we have had some very positive feedback from them. But, again, there are concerns from them. People are very supportive off the record, but on the record it is very difficult getting

them to support us, because they have concerns about their own standing and about whether it is contrary to the politics of their profession and issues like that. When we talk about GPs and referrals, if you look at the British system, through the national health scheme in England, according to the British Association for Counselling and Psychotherapy, over 50 percent of GPs in England have counsellors embedded within their practice. So there is certainly a position for counsellors. I have never had a negative response from a GP talking about using counsellors. It is simply that they work with the system they have and that is what they work with. If they had greater choice to do referrals, I am pretty sure you find the majority would use it.

Dr Jones: And the evidence does show that it is effective in terms of counsellor training and therapeutic practice. It does have a positive effect.

CHAIR: As there are no further questions, we thank you very much. You have got some homework. Senator Moore asked for some additional information.

Mr Armstrong: Yes. Thank you for allowing us to present to you.

Dr Jones: We appreciate it.

NORTHEY, Ms Wendy Lillian, Director, Australian Association of Psychologists inc.

POINTER, Ms Michael Alexander, Executive Director, Australian Association of Psychologists inc.

STEVENSON, Mr Paul Joseph, President, Australian Association of Psychologists inc.

[14:07]

CHAIR: Welcome. I understand that you all have been given information on parliamentary privilege and the protection of witnesses and evidence. We have your submission before us, No. 197. I invite one or more of you to make an opening statement, and then we will go to some questions. I remind witnesses that evidence should address the terms of reference of the committee and that misleading the committee may be considered a contempt. We ask that witnesses avoid making adverse comment against other parties and warn that such reflections may prompt the committee to suspend proceedings. The committee may also decide to take evidence in camera at any stage. Also, witnesses may ask to give evidence in camera. If they do, there is another process we then go into. Having said that, I invite whoever wants to start to make an opening statement.

Mr Stevenson: Firstly, thank you for inviting us to present to this inquiry and an apology for the angst that you might have had to go through as part of the process. I acknowledge our part in that. So thank you very much for inviting us. For my part, I will focus on the two-tiered division between psychologists, and then my colleagues will focus on other areas of the submission.

Prior to the introduction of the Better Access to Mental Health Care scheme in 2006, the profession of psychology contained no registered specialties. Until July last year, all psychologists were licensed to practise across all streams of psychology based on their self-assessment of knowledge, skills and abilities. In essence, registration was a licence to practise everything. Now, with the requirement for areas of practice endorsement, registration is a licence to practise nothing in particular—now referred to as focused psychological strategies.

During discussions in 2006, the council of Australian health ministers allowed a two-tiered Medicare benefit, to reflect the Australian Psychological Society's Western Australian based two-tiered division of psychologists—specialists and generalists. This dichotomy then formed the basis for a differential Medicare benefit at the outset of the Better Access scheme. While it was within the auspices of the APS to maintain its own in-house, two-tiered distinction between specialists and generalists, no such division applied in law. However, in July 2010 the Psychology Board of Australia also adopted the same division and legally enforced the endorsement system to reflect that dichotomy.

The AAPi contends that the PBA has implied a speciality within psychology while the council of Australian health ministers has maintained that the only current specialities apply to medicine, dentistry and podiatry. Further, the AAPi contends that the division of psychologists into two distinct groups is based on invalid premises, and the distribution of government funds—that is, taxpayers' money—is determined now by those invalid premises. Firstly, the endorsement criteria are set upon academic qualification, while the board's charter is set upon practitionership. Secondly, no effective pathway has been provided for recognition of prior learning and development, despite the rhetoric to the contrary. Thirdly, three valid research studies have determined that no between-groups differences apply to performance or client satisfaction. Fourthly, no consultation was ever undertaken with the wider community of psychologists to ascertain their agreement. Fifthly, it is a breach of the profession's own code of ethics to infer that any one psychologist is superior to another.

The implications to the profession of this division are substantial: firstly, the community is deprived of its equality of choice of treating psychologists due to the differential Medicare payments; secondly, unendorsed psychologists are disadvantaged by referral sources; thirdly, unendorsed psychologists sustain lower incomes for the same services performed; and, fourthly, regional and remote communities are robbed of the full range of psychological services that only generalists can perform. Further, transition arrangements for bridging up to endorsement status are stifled by insufficient academic placements in approved masters courses and by the high costs of that further study. Only one tenth of the number of university placements required are actually available for those needing to bridge up. In industrial terms, more than 80 per cent of the psychology workforce is disenfranchised by the endorsement requirement.

The AAPi implores this committee to return the Better Access to Mental Health Care scheme to the community. We ask that you reinstall equality to a profession racked with division subsequent to association

based vested interest. Such vested interest has resulted in a $134 million gap fee over five years, subsidised by Medicare. We ask that you inform the council of Australian health ministers that there is no basis for differential Medicare benefits between psychologists. We ask that the Psychology Board of Australia be advised to abandon the endorsement dichotomy, as it is based on a false premise implying a speciality in psychology where the council of Australian health ministers has determined one does not exist.

Ms Northey: As well as being a director of AAPi, I have been a member of the APS continually for 15 years. I would like to remind the committee of the 30,000 registered psychologists in Australia, 25,000 of whom are now disenfranchised by virtue of not being classified as clinical psychologists, and 75 per cent of those psychologists are female. I am representing those females and all the disenfranchised psychologists—that is, 85 per cent of Australia's workforce of professional psychologists.

Psychology is the speciality. It does not need to be further broken into specialities. It is a specialty just like psychiatry and physiotherapy are. Australia's population is a fraction of that of Britain and the United States. It does not lend itself to small specialties. Australia is the land of generalist practitioners. People present to psychologists and psychologists in Australia have developed a very broad range of skills to meet the needs of the Australians presenting to them. There are no undergraduate registered psychologists in Australia. That is simply an untruth that has been peddled to this committee. All registered psychologists have completed a fourth postgraduate year in addition to two years of supervised practice.

People who need to have specialist skills in relation to something like obsessive compulsive disorder, autism or eating disorder have always been serviced by psychologist who have made it their business to develop special interest areas, and we have all referred to those people if we believe that their area of competence is greater than our own. It has been a method of referral that has worked perfectly. In terms of referring a loved one to the best psychologist possible, you might consider whether you would prefer a referral to somebody who had done two years internship, like a doctor does under supervision, or somebody who had simply remained at university for an extra two years.

In terms of disenfranchisement, and I am talking about 85 per cent of the professional workforce of psychology, at a time when there is a shortage of mental health professionals, including psychologists, I have to ask the committee what government in their right mind would allow 85 per cent of a skilled and experienced workforce to be disenfranchised in this way and then proceed to fund the additional university subsidised placements to train more clinical psychologists. Where is the money coming from? Does it exist? If it does exist wouldn't it be better to use that money to train and educate in areas of skill shortages around Australia, rather than simply disenfranchise 85 per cent of a workforce already skilled and experienced in clinical psychology? Clinical psychology is the heart of practising psychology. You cannot remove clinical psychology from psychology. It is the heart of psychology. We cannot practise without practising clinically.

The two-tier system discriminates on the basis of no evidence. It discriminates against our clients and it discriminates against psychologists. It is unfair, it is not reasonable and it is based on no evidence. In fact, it flies in the face of the evidence that does exist and that was the evidence that came out of the University of Melbourne looking at the outcomes from the better access scheme where it was proven that the outcomes demonstrated no difference between services delivered by so-called clinical psychologists as compared with those who are not clinically endorsed. There should be one rebate for all clients. There is no need for any specialties. Private practices are small businesses. We have been very severely impacted upon by this discrimination. Small practices are struggling because of the unfairness of this. There is not a level playing field. Our clients are expected to forgo the higher rebate for no rational reason. They are the points that I wanted to make. Thank you.

Mr Pointer: I would like to make a couple of brief points about the submission of ours. First of all, I would suggest that we certainly support the thrust in the APS submission as to the retention of the better access scheme and we commend their piece of research on that to the committee as well. That is a very good piece of research. We would actually like to concentrate, as my colleagues have, on two issues: the endorsement of areas of practice or specialities and the two-tier Medicare rebate system. In relation to that, I would like to quote from the submission of the College of Counselling Psychologists. They present the definition of counselling psychologists—and you could refer to the other endorsed areas—as:

> … specialists in the provision of psychological therapy. They provide psychological assessment and psychotherapy for individuals, couples, families and groups, and treat a wide range of psychological problems and mental health disorders. Counselling psychologists use a variety of evidence-based therapeutic strategies and have particular expertise in tailoring these to meet the specific and varying needs of clients.

We would assert to the committee that that definition describes exactly the role and activity of all registered psychologists in the country.

Earlier in the day I picked up the comments about how the profession seems to be torn asunder and how there is a lot of infighting going on. I suggest to the committee that we are here not for ourselves but to advocate for the vulnerable Australians who are deprived of a $38.20 for each consultation. That is a 50 per cent difference on the higher rebate that applies for exactly the same service. It is an enormous differential, particularly for those suffering from mental health problems. We suggest to you that it is unfair and unreasonable to the most needy, and we hope this committee will recommend to fix it.

Senator FIERRAVANTI-WELLS: In terms of going back and looking at options for resolving the issue, do you think it should now come under the national registration framework we now have? I think you were saying that psychology would become another one of those areas that comes under the national registration framework.

Ms Northey: The current Psychology Board of Australia consists of eight members of the Australian Psychological Society, so there are whole sectors that are unrepresented on that board.

Senator FIERRAVANTI-WELLS: What I mean is that, as you know, we now have AHPRA—the new Australian Health Practitioner Regulation Agency. I think Mr Pointer attended the relevant inquiry on that, trying to tell us this very point, but we shut him down. Take your mind back to the evidence you were giving on that occasion, Mr Pointer. I think what you were saying is that it is an option for psychology to come in as the 10th or the 11th area under that AHPRA framework.

Mr Pointer: Exactly. I must say, I was shut down very gracefully on that occasion! But yes: the point we were making and are making again now is that psychology is the speciality within the medical framework, as Wendy Northey said, like psychiatry and physiotherapy. They are not broken down into silos as the previous presenters talked about.

Senator FIERRAVANTI-WELLS: I think I asked this question earlier, but say you have a situation where somebody is just out of university and has basically done the requisite amounts or has done the basic training. Compare that person with someone who has been working for 40 years. In effect, the person with the 40 years of experience—and the person who goes to see that person—is disenfranchised. I think that is basically what Ms Northey was saying.

Mr Pointer: Exactly, and in our submission we have given you examples of exactly that situation.

Senator FIERRAVANTI-WELLS: Is your recommendation that the individual should just get registered as a psychologist, with that single rebate? Whether that goes to the current higher amount or a lower amount, or somewhere in the middle, is not the point you are making.

Mr Pointer: Exactly.

Senator FIERRAVANTI-WELLS: Your issue is not with the financial point. Your issue is simply that it be just one rebate and that anyone who goes to see a psychologist, who is registered within a hypothetical AHPRA framework, would get one rebate.

Ms Northey: That would reflect the situation as it now is that every psychologist registered in Australia has general registration. There is no specialist registration. It is in fact my understanding that it is illegal to refer to yourself as a specialist psychologist because there is no such thing. I am aware that Western Australia has some difference in that regard but in the rest of Australia every psychologist is a registered general psychologist.

Mr Stevenson: The specialty exists in Western Australia only as an in-house APS specialty. 'Endorsement' is a really particular term that we have been trying to get a lot more information about. What does 'endorsement' actually mean? Professor Brin Grenyer, the chair of the PBA, said to me one day, 'The public has a right to know who is better qualified.' To use a term like 'endorsement' we have to ask what it is. Is a quasi-specialty, is it something that implies a specialty, is it something that implies a superiority? It is just a term that the PBA has picked up on that says that this psychologist is better than that one because they have done a masters course in a particular area of practice.

We dispute that endorsement actually means anything in particular. If it is really a specialty, why isn't it called a specialty? Why is it called an endorsement? We came up with the opposite term which is 'unendorsement' and we have been shot down for that because they have said that there is no such term as unendorsement. We think that that is a reasonable term given that there is a term called 'endorsement'.

I would like also to pick up on the presumption that endorsement ought to be applied to a person who has a higher academic education or higher academic qualification because, in fact, the charter of the board is on practitionership and to infer that somebody is a specialist because they have done a coursework masters degree is quite wrong in our view. A coursework masters degree is a general course. It is a generalist course. A group of people do the same curriculum, the same subjects over a two-year period. We believe that specialist training in

psychology is done as a part of continuing professional development. In my area of trauma I will get specialist education when I attend a conference by Professor John Briere, who is a world expert on trauma and post traumatic stress disorder. That is specialist education. Specialist education is not to be found in a coursework masters degree. The presumption seems to be that it is always the case.

There are those with 40 years' experience behind them. There was the case this morning where you asked that question of one of the people here and they said that they might have 40 years' experience but maybe they need to upgrade on this and twig that, and they may not have had the right amount of experience. The whole business of recognition of prior learning is in rhetoric alone. It is not actually an effective pathway. A person with 40 years' experience ought to be able to be endorsed. The people who are being endorsed are not the people that have the experience in the field, they are the people who are 23 years old and have just come out of a masters coursework degree.

Senator FIERRAVANTI-WELLS: In following on, if you were under AHPRA umbrella it would then make it a lot clearer in the sense that that would be the criteria for registration.

Mr Stevenson: In fact we have no problem with the upgrading of academic qualifications provided that it is done in the first intake of the next year of PY101 students in 2012, and they know where the goal posts are when they come into it. What has happened is that the endorsement areas are retrospective. People who have been practising for a lifetime are now deemed to not be qualified to do what they did on 30 June 2010. We believe that they should have been grandfathered to the new area of practice endorsement but no grandfathering was done. So we have a retrospective issue, whereas progressive educational study ought to start from the next year on.

Ms Northey: The APS have argued here today that there was an opportunity to apply under a grandfather clause. However, at that time we were aware of applicants with PhDs who had been practising for 30 and 40 years who were being knocked back. We had to attach a cheque for $500 to every application. If we wanted to appeal a decision we had to give them another $1,000. It is not surprising that a lot of people felt so demoralised that they thought there was no point in applying. So many people we knew with strong applications laying out their life's work were simply knocked back and told to go back to university. Some people said: 'But you can't tell me to go back to university. I got my degrees 25 and 30 years ago.' They were told: 'In that case, they're now out of date. You'll have to go back and do a new undergraduate degree and start all over again.' We failed to think of another profession in Australia where a precedent like this has occurred.

Senator FIERRAVANTI-WELLS: To take that further, you would find yourself on the same footing as somebody who had effectively just come out of university.

Ms Northey: Personally I hold young professionals in very high regard.

Senator FIERRAVANTI-WELLS: No, I do not mean that in any derogatory sense.

Ms Northey: The only thing is, if only we were on the same footing. The fact is we are not. You can come out with a clinical masters degree and be endorsed immediately to provide services at a higher rebate than people like me who have been practising for 15 years. I am not on an equal footing with them. They are way beyond where I am, and that is what is so unfair. There are people like me: I have three children, I went to university as a mature-age student and my family sacrificed a lot to get me qualified. I am now fully qualified having practised for 15 years and I am being disenfranchised out of the blue. I cannot go back to university as there are no places for people like me. I would not be able to gain entry to requalify. We have simply been left high and dry. I have bought an office. We have financial commitments. We have built our life around our chosen career. No regard has been given to that in this unfair endorsement and rebate system. One small group of psychologists is simply claiming superiority, getting on to all the boards, making all the decisions, hiving off 4,000 psychologists and literally running away with the ball, leaving 85 per cent of the profession disenfranchised.

Mr Stevenson: There is another very important point to endorsement that has not been raised yet, and that is that the presumption is that a person would need an endorsement in only one area of practice. It is a nonsense that that would be the case. In my own practice, where I do psycholegal assistance and reports, in order to that I would need three endorsements: clinical, forensic and organisational. I already have an organisational endorsement, but I am not going back to uni to do two more masters degrees to continue to do the work that I have been doing for 20 years. There will be very few psychologists who can get by on one endorsement area. They will need two at least, even if they are just working in a counselling interface. There they will need a counselling endorsement in a clinical setting, so they will need two. Some will need three. It is not the case that anybody can set out to do a particular job with one endorsement area.

Senator FIERRAVANTI-WELLS: In relation to the National Mental Health Commission, I note your comments. I will not pursue that as I am conscious of time.

Senator MOORE: Who should fix it? We have had the argument that they are all over it.

Ms Northey: The profession should have prevented it from happening in the first place.

Senator MOORE: It is too late for that, Ms Northey.

Ms Northey: And the profession should fix it. It is a disgrace.

Senator MOORE: We discussed at length in the AHPRA process the fact that your profession was not in it. We asked why you were not there, and it was difficulty in getting agreement which is one of those circular arguments: this should be where it happens; why aren't you there? Because you cannot get agreement in the profession, so you go round and round and round. I think all we as a committee can do is note what we have got in terms of the process. In the submissions we have received there has been amazingly strong evidence on something that is not part of the terms of reference.

Senator FIERRAVANTI-WELLS: Senator Moore, it is specifically part of the terms of reference.

Senator MOORE: It is not part of the process of the changes in the government's mental health process. In terms of where we go with it, I have not seen a recommendation from either group that says, 'This is how it should be fixed.' It would be very useful—

Mr Stevenson: I would like to put forward a recommendation.

Senator MOORE: It is not in your submission. It would be very useful to have how it could be fixed—not that it should be fixed but how it could be fixed.

Mr Stevenson: The recommendation is that we turn one year back to June 2010 when full registration was a licence to practice according to one's own skills and abilities and self-assessment of such. The registration boards were there to prosecute anybody who did it badly or wrongly or was complained about. That was a perfectly good system. It worked very well for many decades. To me it is a return one year back to the point at which we had some kind of equality. The division is solved when we are on the same level and all on the same Medicare rebate and can move across areas of endorsement or areas of streams, as we used to call them in psychology, at will and provide a full service to the community. The community is robbed by this overspecialisation and this infighting and division that has happened in psychology over the last year.

Mr Pointer: The new national law was actually an attempt to fix something that was not broken. We would be very happy to make a supplementary submission to you on that subject.

Senator MOORE: That would be very useful. I understand the point you are making that you should go back to what happened before. That does not help me as an individual—and I do not know about my comrades—with how that should be done.

Ms Northey: We do not need governing boards that are riddled with conflicts of interest and vested interests for a start.

Senator MOORE: That is in your submission. As you know, that is subject to negative comment. We have got that and we have gone through the process. I and the committee would find it very useful to have a recommendation about what should happen and how it should happen.

Mr Pointer: I am conscious of the fact that you are running a whole series of inquiries at the moment. When would you like that submission by?

Senator MOORE: By 5 September.

Mr Pointer: That would be no problem.

Ms Northey: The majority of Australian psychologists are mortified by the situation that has arisen and the divisions that have occurred. They are a conservative profession. They are not used to having to deal with something like this. They are simply mortified.

Senator FIERRAVANTI-WELLS: Does that mean that the psychologists need psychological treatment?

Ms Northey: Definitely.

Senator ADAMS: I want to come back to the question I have been asking all the time about how you see your profession interacting with the divisions of general practice and the new Medicare Locals. I am trying to build up a profile on how everyone sees themselves fitting into those.

Mr Stevenson: Our opinion is that the ATAPS funding is targeted towards a client group which requires case management as its primary service. Multidisciplinary teams operate to help people who are homeless and need housing and who are alcohol intoxicated and need detox. A whole range of services can be only provided by case managers and not psychologists. Psychologists are not the right people to be doing that. That money will go into

services within offices that last 50 minutes. What is needed is for ATAPS to be directed more to community services like community health centres, community mental health centres, social workers, nurses and welfare officers. Members of Mr Armstrong's association are much better equipped to do the case management; psychologists are not. We would like the traditional services to take over—the NGOs and the church based services—and to get on the boards of the Medicare Locals and be the people to whom ATAPS funding is directed.

Senator ADAMS: If I can take this to a rural setting, do you see that you have a different role there?

Mr Stevenson: In rural settings we have to be generalists; we cannot be specialists. For a psychologist in a rural town, that person has to be able to go to the schools and the hospitals and see people with relationship problems, be able to deal with alcohol and detox problems and be able to deal with all kinds of issues in one town. We desperately need the generalists in Australia to do that. We cannot follow world's best practice, which has been put forward here, to go into specialisations, because world's best practice to the people who espouse it is North America and the UK, where you can walk to the end of your street and find all nine areas of practice in psychology represented. That does not happen in Cunnamulla, it does not happen in Alice Springs and it does not happen in places within Australia where you can put a compass point around your home and draw a circle of 1,000 kilometres and not find a single psychologist.

Ms Northey: We were very impressed with the two women who gave evidence before lunch, genuinely focusing upon their clientele and describing their service delivery situation. They indicated a lack of resources and the waiting lists for psychologists as well. The integrity of their profession really shone in contrast to what has happened to ours.

Senator ADAMS: That just shows that they have been able to work together as a team. They all trust one another.

Ms Northey: They have shared goals and good communication.

Mr Pointer: I actually live in their area and they are excellent.

CHAIR: You made a comment earlier about fixing the system if you went back to one tier—that it would fix the system.

Ms Northey: It would eliminate the inequity based on no evidence.

Mr Stevenson: It gives the community a real choice, because it is a market driven differential in payments at the moment. The consumer has to look at who gives the best rebate or 'What is the best rebate I can get back for the amount of money that I pay if there is a gap?' There is a 50 per cent differential in the markets. Consumers are on waiting lists for the 20 per cent of people who can charge the highest rebate and 80 per cent sit idle.

Senator FIERRAVANTI-WELLS: Protectionism in reverse.

Mr Stevenson: Yes. So the community is better serviced with one tier. We do not necessarily hold any agenda as to whether it should be the higher one or the lower one or something in between, but one tier gives people real choice and real accessibility to psychologists, and that is what is important.

CHAIR: With all due respect, at this stage it is not going to fix the issues within the sector, because it seems to me that they are pretty deep.

Mr Pointer: They are actually separate issues.

CHAIR: Yes, but there were comments made earlier about going back and helping to fix the divisions that have arisen. I do not think it is as easy as going back to one tier.

Mr Pointer: That will not be as easy to fix, but they are two separate issues. Although they have become intertwined, they are actually two separate issues and they come from two separate origins.

CHAIR: You mentioned this before. I just want to check it. Let's put the two-tier thing aside for a minute. In terms of the other area of our terms of reference, better access, do I understand it correctly that you are endorsing basically what APS has said in terms of their comments on better access and changes to better access?

Mr Pointer: Yes.

CHAIR: Let's put that aside as well. In terms of the other initiatives that have been brought in with the announcements that were made with the budget, putting aside where the money is coming from and the changes to better access, do you support the other announcements that were made on flexible packages, the focus on early intervention and focusing on very young people?

Mr Pointer: In principle, but some of our members are concerned about some of that money actually going to what could effectively be described as untried systems, where there is, perhaps, overemphasis on medication.

CHAIR: I do not want to put words in your mouth, but I do need to tease this out a bit: are you referring to the early psychosis where comments have been made in the media, or something else?

Mr Pointer: Yes, the early psychosis. But in principle we agree with it.

CHAIR: Okay.

Senator MOORE: But you have also clearly said in your recommendation that you think the money that was taken from Better Access and going to ATAPS and headspace should go back the other way?

Mr Pointer: Yes.

Senator MOORE: So you want ATAPS and headspace reduced?

Mr Pointer: And some of the other programs.

Senator MOORE: You specifically mentioned that in your recommendation.

Mr Pointer: It could be argued that too much funding has gone to headspace, for instance.

Senator MOORE: Yes, it is just that they are the only two you have mentioned in your recommendation—ATAPS and headspace.

Mr Pointer: Yes.

CHAIR: I was trying to tease that out a bit further: if you had a magic wand and you could produce as much money as was needed to put into mental health, which is why I was taking Better Access out of the equation, would you then fund or support the programs that were in the package? That is what I wanted to know.

Mr Pointer: When you find the magic wand, can I borrow it for a day?

CHAIR: Yes. I will wave it around a little bit more for a while.

Ms Northey: We would prefer money to be placed where there is evidence that it will be effectively utilised.

CHAIR: Do I take it from that comment that you think investment in the early psychosis area—and I am not trying to put words in your mouth—

Ms Northey: No. All I can say is that one of our board members who has more experience than any of us three in the area of early psychosis is of the strong view that there is not sufficient evidence to support the investment of vast amounts of money when there is evidence to support the outcomes of, for instance, Better Access. He would rather see the money come back into Better Access to be effectively utilised.

CHAIR: I appreciate that, and I know it is difficult to answer but I am trying to tease out if, for example, we were to argue that there should be more money instead of robbing Peter to pay Paul, as some people are saying, are the programs good programs in themselves? Do you see what I mean? I am trying to differentiate—

Ms Northey: All psychologists will argue that early intervention is the most effective. Most psychologists would come back in their second life to work in child psychology in order to get in early to prevent the development of more serious problems in adult life. Of course, money into young people is always a wonderful investment.

Mr Stevenson: Just to add to that: we agree that EPPIC and headspace are very good programs and that they deserve to be funded. But there is plenty of evidence for Better Access as well. What generally happens in Australian politics is that certain political parties are able to make notoriety by funding high-profile kinds of schemes from time to time. We believe that that is what has happened with regard to the sort of funding that has come into those two centres. But generally speaking, there is strong evidence for Better Access to take that; better evidence, I think, than there has been for the other programs.

Senator ADAMS: I was going to ask about the online technology and where you see that going with mental health services, especially going out to more remote areas?

Ms Northey: Of course, you would never ignore the potential of any advantage that can be identified. It would take good research and evaluation to determine how it could be exploited, but in a country the size of Australia, with its vast outreaches, it is tempting to say that it could be a solution.

Senator ADAMS: Have any of you had any experience with that?

Mr Stevenson: I did have some experience many years ago when the technology was not really available to have online interface with people in rural communities. But there was a strong push about 10 years ago to do this. I cannot remember the actual name of the program now. Generally speaking, if the technology works and people are assisted by it, and the evidence is coming back that it is working, then we would support it.

CHAIR: We have talked about GPs and plans, though we have not talked about this issue so much today. We have had some evidence from some people that they are very effective and others say they do not think they are

necessarily as effective as they could be. Then there is the evidence you heard this morning around not being able to get to GPs to get a plan in regional areas.

Mr Stevenson: Up until the Better Access scheme it was not necessary for referrals to come from GPs. People could simply access their psychologist and if they had a private medical fund behind them then those payments would come through. On the issue of the gatekeeper role for 2710 mental health plans and the like, we do not actually have a policy but we do have an opinion. And the opinion is that it is a very expensive gatekeeper and it takes quite a substantial amount away from the mental health budget. However, there is no other solution to it when you are distributing taxpayers' fund. It not the same as a private insurance company's funds. So there needs to be a gatekeeper, but this just happens to be a very expensive gatekeeper. If it could be done in some more efficient way, then we would support that.

Ms Northey: It varies: some of the plans are very good and some of them are virtually non-existent. I personally like the idea of using GPs as the gatekeeper, and I think they need some incentive. GPs work under great pressure and they need some incentive to make those referrals. In the past we did not get those referrals. GPs were not referring sufficiently to psychologists or even psychiatrists. So anything that encourages them to do that is a good thing, I think.

Senator FIERRAVANTI-WELLS: There was evidence earlier about, effectively, Better Access versus ATAPS, and the value for money of the two—Mr Stevenson, you might have been here then—and this sort of push of moneys going from Better Access over to ATAPS. Some of the evidence given earlier was that, as a consequence, potentially 87,000 people will miss out. Do you have some views on that?

Mr Stevenson: Again, those with very chronic mental illness will require more than six, 10 or 18 consultations a year. They will need monitoring on a regular basis. ATAPS is designed to meet that need. And you would think that if you put more money into there and away from Better Access then more people with severe disease states are going to get more assistance. But, as I said earlier, I think that money to ATAPS has to go into the right treatment facility, because psychologists do not do case management, and to steer the money away from psychologists Better Access into psychologists ATAPS does not make sense to me. To steer it into ATAPS for traditional, group based, case management services, as I explained earlier, does make sense.

The other thing that makes sense about that is that there will be some sort of a differential saving in the cost as it goes down—I go not want to be arrogant about it, as it goes to the people who traditionally charge less anyway. I think the money will probably spin out further in the hands of the NGOs and church based agencies and community health centres, with the funding that they already get from state governments to assist with that. I think we will get further with ATAPS if we use the money in that way rather than taking it from the Better Access.

Senator MOORE: Help me on this: I take that argument, and that is seemingly where some of the discussion has gone, but what about the people who are currently using the 18 consultations—are they not chronic?

Mr Stevenson: No. There is not the same—

Senator MOORE: So you would make need to make a differentiation between those with chronic conditions and those with others.

Mr Stevenson: That is right.

Senator MOORE: How would that be done?

Mr Stevenson: A person who has 18 consultations in a year will not be considered to be a chronic severely mentally disabled person, because that person will require 50 sessions a year.

Ms Northey: You could be a victim of childhood sexual abuse, however, for instance.

Senator MOORE: Who are already outside the current available systems.

Mr Stevenson: If we are talking about people who are homeless, unemployed and socially isolated as a result of a severe mental illness like schizophrenia, these are the people who will require weekly monitoring by a health professional. That health professional would probably be a psychiatric nurse, a social worker, a welfare officer. They are all equally able to assist that person. Coming back to what Mr Armstrong said earlier, we do not want to be having surgeons putting on bandaids. That is not cost-effective to the community. So it is best that the ATAPS, if it can extend to 50 or more sessions a year—whatever it extends to—actually is distributed to those who can provide that real case management service, the people who will get on the phone and they will ring a housing authority to see if they can find a place for a homeless person. Psychologists generally do not do that. We would be more inclined to say to a homeless person, 'Well, how do you feel about that?' It is not within our training, but it is well and truly inside the training of welfare officers.

Senator MOORE: So in the current system you have six up to 12 and then you go back to the doctor and, in what is described as exceptional circumstances, you can get six more. There is a view that a lot of the people who are doing that are the kinds of people you were just describing.

Mr Stevenson: Who psychologists will still see and who are not chronically mentally disabled.

Senator MOORE: From your organisation's perspective, there is a pathway—

Mr Stevenson: We would still like to see the 18 sessions available.

CHAIR: Could I just clarify that? Of those who would be using the extra six at the moment, there are two groups, it seems to me. There are those who are not chronically ill but need 18 sessions and then there are the other group we are talking about, who are the chronically ill—

Mr Stevenson: Yes, who will require more.

CHAIR: What would be the breakdown of that? As we understand it, there are 87,000 who use between 12 and 18 who—with it now going back to 10—would fall out of the system. They are currently able to access the system but they would fall out of the new system. Of those—this may not make sense—how many would you be confident could be kept well with an additional six sessions and how many do you think are chronically ill who are not managing under the current system anyway and we really should be making other services available for them?

Mr Stevenson: I would suggest that almost all people who come to a psychologist with a substantial emotional difficulty, a depressive situation, an anxiety situation, a traumatic occurrence, would require 18 sessions. Brief psychological therapy exceeds 10 and goes up to 20. That is considered brief psychological therapy for a person who is undergoing a severe life difficulty. They are not the chronic people. The chronic people come after that and require weekly or fortnightly monitoring lifelong. I would say psychology desperately requires the 18 sessions to do its job.

Senator MOORE: For the people who need that.

Mr Stevenson: For the people who need it. I take the point that was mentioned earlier that, after 10 sessions, if you were to then break to another therapist it really would be a regression because you start at the very beginning again. There is a critical mass in terms of therapeutic sessions that will allow a person to overcome a substantial life difficulty. Eighteen sessions, I think, is—

Senator MOORE: The critical mass.

Mr Stevenson: definitely sufficient and not oversufficient.

Senator MOORE: One of the core difficulties—and it is a threshold issue—is: how many of that 87,000 who have been calculated who have taken between 12 and 18 sessions fit in that category? One is too many, but—

Mr Stevenson: I know the question you are asking, and I do not have the stats on that.

Senator MOORE: I do not think anyone does.

Mr Stevenson: I heard that figure today for the first time.

Mr Pointer: That would require a considerable piece of research.

CHAIR: That is what I was after. So the answer is: we need some more research. It is three o'clock, which means we are at the end of this session. Thank you very much.

Mr Pointer: Could I just make two points?

CHAIR: If they are quick.

Mr Pointer: Very quick. First of all, I just want to reiterate Paul's comment about the small hiatus we had going through this process and to acknowledge how gracefully your committee secretary handled all that. I would like to do that, because he did it very well. Secondly, we have a page and a bit of a summary of what we have talked about today, and I would like to seek leave to table that.

CHAIR: Yes, you can seek leave and, yes, you can. Thank you very much.

Proceedings suspended from 15:01 to 15:21

LLOYD, Miss Sian, Senior Policy Adviser, headspace

TANTI, Mr Christopher John, Chief Executive Officer, headspace

CHAIR: Welcome. I understand that information on parliamentary privilege and the protection of witnesses and evidence has been provided to you, and we can provide helpful, handy hints again if you want. That is correct, isn't it—you have seen it?

Mr Tanti: Yes.

Miss Lloyd: Yes.

CHAIR: We have your submission; it is No. 169. In a minute I will ask one or both of you, if you want to, to make an opening statement, and then we will ask you some questions, but I have an extra little bit to read that we have been reading all day. The committee reminds witnesses that evidence should address the terms of reference of the committee and that misleading the committee may constitute a contempt. We ask that witnesses avoid making adverse comment against other parties and warn that reflections may prompt the committee to suspend proceedings. We are able to take evidence in camera at any stage, and you are able to request to give evidence in camera at any stage. We kick into a different process if that is triggered. Having said that, I invite you to make an opening statement.

Mr Tanti: Thank you very much, Senator, and thank you all for inviting us to appear today. In our statement we will focus on the mental health needs of young people specifically, the headspace model and some of the issues arising from the proposed rationalisation of Better Access.

Mental health is a major issue faced by young people, with as many as one in four young people experiencing a mental disorder in any one year. It is estimated by Pat McGorry that in Australia approximately 750,000 young people have mental health problems that are not met. Headspace is committed to providing young people with holistic support for mental health, physical health, education, employment and drug and alcohol concerns. Further, funding enables us to extend our services to provide a youth-friendly space for young people to receive help.

I do not think that many people are aware of how a headspace centre operates, what the government funding covers and the diverse range of professionals that are at the heart of the initiative. It is also important to preface any discussion about headspace with an important fact—that is, headspace is an emerging proposition. Most centres have only really been operational in the last 2½ years, and, for a variety of reasons including location, fit-out of premises, recruitment of workforce and the complexity of consortiums, headspace centres take some time to establish properly.

The Commonwealth government funding allows for the existence of the headspace site, including rent, infrastructure and some salaried operational and clinical welfare staff. The breakdown under the old funding formula was that 13 per cent was spent on site infrastructure, 14 per cent on program infrastructure and 73 per cent on staffing, including 2 EFT clinical admin staff and management. The Commonwealth funding does not cover all service provision. Headspace centres use hybrid sources of funding to build a multidisciplinary team. This includes the funding scheme's Better Access and, in some centres, ATAPS—though here eligibility is the issue, with most of our clients not meeting the threshold for a mental health diagnosis. In addition and importantly, the latter relies largely on the cooperation of local divisions of general practice.

The headspace model encourages co-location integration of subcontractors—GPs, psychologists, mental health nurses, social workers and occupational therapists—who bulk-bill clients through Medicare. In addition, the headspace centre provides the platform to the co-location of state funded services that are funded to see more complex presentations, including serious mental illness, drug and alcohol problems and vocational services. Additional services can include law enforcement agencies, sexual health services, homeless services, youth services and Indigenous health services and schools. The model ensures that regardless of the complexity of the presenting issue, the young person will receive the service.

The staffing of the headspace centre includes salaried staff, co-located private providers who are self-funded through the MBS and co-located workers from consortium members and other agencies. I have a breakdown, which is impossible to work my way through, but essentially we have about 75 staff that are funded through the Commonwealth grant for headspace and 63 staff—roughly 63 EFT—who are providing services under the MBS. As an example of those who are providing services under the MBS we have about 8.6 EFT of GP time, which is

spread across seven centres. The 8.3 is misleading because there are actually about 43 individual GPs working across headspace centres but they are largely doing sessional time.

Young people come to headspace with a range of issues. Mostly they self-refer or are referred by their families. In fact, that represents 50 per cent of the young people we see. They rarely identify as having a mental health problem. They come because they feel down, trapped, stressed, bullied, have problems with relationships, have problems holding jobs or have problems maintaining concentration. As one would expect, the language used is mainstream and is not easily translated into specific diagnostic criteria or categories. While these problems may seem small or even trivial to the older generation the consequences can be significant and may include family discord, isolation, decreased attendance at school and at work, self harm and, in its most extreme, suicide.

The demand service has exceeded my expectations. We have provided services to 50,000 young people—29,208 in the last year—and have provided half a million occasions of service. In one of our centres referrals are eight times those of the local CAMHS service. So, in a sense, headspace is a successful program.

One of the main achievements of headspace is that it is treating young people with high-prevalence disorders and importantly they are coming to us early. Depression and anxiety are the most common mental disorders amongst young people and it is estimated that one in five adolescents is likely to experience a diagnosed or depressive episode by the age of 18. Consistent with these studies, our data show that most mental health problems young people present with at headspace are depressive symptoms, representing 33 per cent of the young people that are seen, and anxiety symptoms representing 18 per cent.

Headspace centres are also intervening early in the stage of illness. In the last quarter, over 50 per cent of headspace clients who had a diagnosis were assessed as being at stage 1, 34 per cent at stage 2 and 15 per cent at stage 3, the full threshold for meeting the diagnosis. It is important to note that prior to the establishment of headspace these people were locked out of public mental health services. I now want to discuss the role of GPs at the headspace centre and also the implications of the rationalisation of the better access program. An important part of headspace is collaboration with general practice. Headspace is an enhanced primary care model. In the headspace business model, patients are initially triaged and, where appropriate, an appointment is made with a GP. GPs are the gatekeepers to access psychiatry and the MBS-funded allied health services. To get a sense of the volume of work in relation to mental health treatment plans, GPs internal to the program created 2,736 mental health care plans and GPs external to the program—GPs outside of the headspace model—created 5,065 mental health treatment plans.

Most young people do not have their own GP and often the only GP they have access to is their family GP. While this, in and of itself, is not a bad thing, young people report that they find it difficult to disclose their problems to family GPs because they fear the consultation will not be confidential. Importantly and of more relevance here, within the headspace model GPs spend on average up to an hour with each young person. Unlike older patients, young people often present for the first time with little medical history and no prior physical or other investigations including those related to substance use, mental health and sexual health. Developing trust in the first encounter is critical to health outcomes and consequently more time needs to be spent in that context to complete assessments and undertake a thorough investigation.

In order to develop an appropriate clinical impression of the young person, longer sessions are essential with this age group. Research has shown that assessment of a mental health problem in young people must foster engagement and have sufficient time and scope to assess the psychological needs as well as the mental health problems. Headspace utilises the holistic HEADSS psychosocial assessment with young people, through which the GP determines the young person's needs in relation to the home environment, education and employment activities, drug and alcohol, sexuality and relationships and stress including suicide risk. A preliminary evaluation of the HEADSS assessment used in headspace centres shows the majority of clinicians, 56 per cent, reported the assessment takes 60 to 90 minutes to complete. Often there will be additional time taken in liaising with schools, family and other community services to ensure that the young person's needs are met.

It is likely that any changes to the remuneration levels of GPs will likely result in GPs reviewing the viability of performing mental health treatment plans, particularly in an environment where their patient requires longer consultation and follow-up. Mental health treatment plans are a core activity for GPs working in a headspace centre. For example, analysis of 28 out of our 30 centres showed that in the last financial year item No. 2710, for a 40-minute preparation of a mental health treatment plan, equated to over one quarter of the total GP revenue billed at headspace centres. The proposed rationalisation of the better access initiative will equate to a projected reduction of 20 to 50 per cent of income across the different item numbers for GPs working in headspace centres. We are concerned, naturally, that a reduction in income will act as a disincentive for GPs to engage with the headspace model. We recognise that in some cases GPs have not been undertaking the mental health treatment

plan in a robust manner. This is not the case in the headspace centres. GPs have been providing a quality service and should be recognised for doing so. We are also concerned that the cost GP is passed on to the patient. Costs can be a major barrier to timely access to medical care and it is a particularly strong barrier for young people who are no longer supported by their parents. Reducing the rebates will act as a disincentive to access care for many vulnerable young people. That is essentially all I have to say.

CHAIR: Miss Lloyd, do you want to add anything at this stage?

Miss Lloyd: No, thank you.

CHAIR: We will go to Senator Fierravanti-Wells.

Senator FIERRAVANTI-WELLS: Mr Tanti, can I take you to a couple of points in the submission. On page 4 it is said:

The proposed rationalisation of the Better Access initiative will equate to a projected loss of 20 to 50 percent of income across the different ... Item Numbers ...

That is a quite substantial amount.

Mr Tanti: It certainly is, and I have been speaking to GPs within headspace centres. As soon as the announcement was made in May, I had calls from a number of GPs within headspace centres concerned about the impact on their income and they stepped me through essentially their interaction with patients, justified the amount of time that it took to spend with a first-presentation patient and basically said, 'Look, I'm going to have to review my involvement in headspace.'

Senator FIERRAVANTI-WELLS: And it is already difficult to get GPs to collaborate in those circumstances. Are you at the point where it is seriously affecting the operations of some of your centres? You have obviously had to look at the headspace sites around the country; are we at the point where we are concerned? It is not coming in until 1 November, but you have obviously got to look at some planning issues.

Mr Tanti: The calls from the managers have stopped, I guess, and the calls from the GPs have stopped, but I am pretty concerned about the impact in the medium term. The majority of GPs who are working in our centres are very passionate about working with young people, and I suspect what will happen is that they will reduce the amount of time that they spend at the headspace centre—because they actually enjoy being part of the headspace environment, they enjoy working with a multidisciplinary team, they enjoy working with the clients, they enjoy working with young people. So I suspect they will not leave entirely but they will reduce the amount of time they have available at headspace.

Senator FIERRAVANTI-WELLS: And then you might find yourself in circumstances where you have to rely on smaller contributions of time from more GPs. Whereas one of your sites might have had three or four GPs previously, you might end up having five or six but with each doing less time, which of course makes it more difficult in terms of dealing with younger people and the issue of continuity.

Mr Tanti: Yes, absolutely. If you think about it in terms of some of the higher volume centres—and I mentioned that at one of our centres the referrals are eight times those of the CAMHS—the only way you can deal with that those volumes is by having GPs and allied health practitioners. Luckily enough, in that area the allied health staff are flocking to the centre and we do have reasonable levels of GP input. If that were eroded, then we would have a problem in that we would not able to meet demand.

The difficulty with the model in the past is actually that the real estate for the headspace centres has been too small, because, again, none of us anticipated the demand, and so most of the centres moved into relatively small premises. This centre, for example, has 300 square metres of space and is moving to 700 square metres of space to accommodate the demand in that area. They have the GPs interested in working in that space; they have the allied health practitioners. My concern is that we have only just got the business model right, and this could have a negative impact on the model.

Senator FIERRAVANTI-WELLS: On page 6 of your submission, Mr Tanti, you say:

… a different funding model is required for young people …

Could you just elaborate on that. You draw an analogy with the Mental Health Nurse Incentive Program; could you tell us a little bit more about that?

Mr Tanti: I guess the thing that works in the headspace environment is the collaboration and cooperation between various community agencies and various professionals within that context. In terms of the mental health treatment plans, in my view the reason they are done so well is that they actually have to work with the professionals within that context, so they have daily relationships, they have an ongoing professional relationship with those people—they pass them in the corridor et cetera. I think that is why our mental health treatment plans

are well done. I have not heard any complaints internally about the way GPs complete these plans. In speaking to GPs in the community, they absolutely accept that some of their colleagues have not necessarily done the right thing in this space; but, in the context of an environment where people are having to have ongoing relationships, it makes sense.

The other thing about headspace is that we are talking about young people who, developmentally, are at a particular stage where they are very complex, and so they are presenting with a range of challenges that take some time to sift through. They are unknown quantities. And this is what the GPs are saying—that they are actually not educated in relation to their mental health, substance use or sexual health. An obvious solution would be to have a particular item number in this space—a youth mental health or a youth health item number. I know that in New South Wales they have been arguing for this for some time, and it makes perfect sense to me.

Senator MOORE: We heard this morning from the college that there is particular interest in GPs' concerns about how they could lose money. That came up when we questioned the first group of witnesses. I am interested in what you said in your evidence that the standard is a 60-minute consultation—although I realise you can never really have a 'standard' in this area. Would that be about right?

Mr Tanti: Yes.

Senator MOORE: That is the element of the proposed GP reduction that is the lowest. In your evidence you said that it was going to be 20 to 50 per cent. It seems to me that if the GPs are doing that kind of work for that length of time—which is what we expected when the program was introduced—the reduction would not be to the 50 per cent level. If the changes come in, there is going to be a 23 per cent reduction for the core item number for consultations over 40 minutes. I am not saying I am supporting any reduction; I just want to get the quantum of the figure. The figures just grow in your mind. You hear so many figures being bandied around, but I did think I heard in your evidence that the mental health work of GPs in your area made up about a quarter of the work. They are doing other standard consultations, including illness, sexual health and all those things.

Mr Tanti: And they are doing follow-ups.

Senator MOORE: That mental health plan element is absolutely core to what you do. Because of the complexity of the cases, the most regular way to do it is to have about an hour for the consultations. Is that right?

Mr Tanti: It would be an hour plus, yes.

Senator MOORE: Currently the distinction is made between up to 40 minutes and over 40 minutes. I am not sure why 40 minutes was chosen, but that was the magic amount. The proposed reduction there is 23 per cent.

Mr Tanti: Yes. I have it at 22.6 per cent in my calculation, and what you are saying makes perfect sense to me.

Senator MOORE: Yes. I just wanted to be clear on the impacts. I know how many people love working in this space, because they get so much out of it. But purely financially, with the reduction in the creation of the mental health plan component there would be a cut, is that right?

Mr Tanti: Yes, absolutely. What they are saying to me is that they are already not remunerated appropriately given that they are often doing well in excess of 60 minutes. That provides a further disincentive. It is actually not so much the money that they are unhappy about. The issue is that they are not feeling valued. I spoke to 140 GPs in Sydney a couple of weekends ago, and that was their feedback. I was there to talk about something completely different and I was interrupted 10 minutes into the conversation with feedback about how hard it is to do an assessment with young people and how hard it is to work in this space, only to be told that the funding is going to be cut. That creates enormous disincentives and also makes them feel pretty ordinary.

Senator MOORE: And it does not matter how much you tell them where the money is going, because it all comes back to their own view. That is an important element. From my perspective, I am just trying to grapple with the figures.

Mr Tanti: When we put the financial modelling to the department last year, the modelling was based on how GPs were remunerated in allied health at that time. The request was for bigger premises, for enough money to promote the infrastructure and community development.

Senator MOORE: You asked for flexible services and all those sorts of things.

Mr Tanti: Absolutely. So we did not anticipate that this would happen.

Senator MOORE: Taking from Senator Fierravanti-Wells's questioning, that is one of the reasons you went on with your proposal for the special youth component, and I think you have argued that in the past as well.

Mr Tanti: Yes.

Senator MOORE: In the current context it takes on an even greater import.

Mr Tanti: Yes.

Senator ADAMS: I would like to follow on in much the same vein. Mr Tanti, from reading your submission it is obvious that this field of youth mental health is becoming a very specialist area You spoke about GPs having to do extra training or your allied health people having to do extra training. Is that actually happening?

Mr Tanti: Yes. We are funded to provide professional development to all the clinicians engaged in headspace centres and anybody else who is interested in the community. We would engage a whole range of community providers, whether they are engaged in headspace or not. If they have an interest in learning about youth mental health we provide training for them.

Senator ADAMS: But do you think the GPs need to gain a special skill in that respect?

Mr Tanti: Yes.

Senator ADAMS: Or do they need more training than what they are getting in their general practice training?

Mr Tanti: If the criticism is that GPs are not skilled enough in this space—and I think that is how GPs are hearing it—then they are happy to be trained up, and we are happy to work with them on that. So yes: I think it is a specialist area. We need to be offering training specifically for GPs, and I think they would welcome it.

Senator ADAMS: Would you consider that they would need to be remunerated with another item number for having those extra skills or getting themselves up into that specialty area?

Mr Tanti: That is hard for me to answer. I feel as though I am about to start speaking for GPs—and I am sure the AMA would have a view on that! But I would have thought that if GPs were appropriately qualified and providing evidence based services in headspace centres—which I am sure they are—then they should be remunerated accordingly. I guess we are all used to the item numbers being at a particular level. If there is an additional impost around training to maintain the item number as it is, I would have thought that most GPs would welcome that.

Senator ADAMS: The other issue is the improvement in technology. We have seen the advent of Skype, which seems to be terribly popular. Could you explain where you think that would go?

Mr Tanti: I think the sky's the limit in that space, really. This is an area that young people are very familiar with. Texting and online and web based counselling are absolutely things that we are about to get into. For the past 12 months we have run a trial online counselling service in remote WA. It went relatively well. I say 'relatively' because young people heard about it from all around the country, so they were coming not only from remote WA but from everywhere else. That said to me that there is a significant need in the community. My view is that we will provide a national online service, and that will occur by the end of the year. We are ramping up as we speak. But it is one-dimensional. There are people who are going to be online who will need another type of service. My view is that that should be integrated into face-to-face care, into headspace centres and into areas in the community that do not have headspace centres. It is a really good mechanism for young people, given the stigma in this space, to be able to get online and have a chat about how they are feeling about particular things in the comfort of their own bedrooms, without anybody else knowing.

CHAIR: Perhaps I could go back to the issue of better access and the concept of a youth MBS item number. How would you see that working? You will be aware that we have had many submissions around better access, and we have heard a lot of talk about it today. In your submission you were talking about the fact that it is not adequately delivering for young people and that there needs to better provision. Perhaps you could articulate just a little bit further how you would see that work.

Mr Tanti: People talk about headspace in terms of its being a mental health service. I actually see headspace as much more than that. It is a bit more comprehensive than just doing a mental state exam. The assessment is generally around all the health issues for young people, so it is a comprehensive medical mental health assessment, sexual health assessment, drug and alcohol assessment and so on. So it is a very complex arrangement. We have a HEADSS assessment tool that we use that GPs need to work their way through. I think the idea of a particular item number is our way of saying that the complexity of adolescence needs to be acknowledged, and that would ensure that all those things occur within those item numbers.

Again, in discussion with GPs, they have the paperwork to fill in, but I do not think there are very clear expectations from their perspective about what should be in there and how much detail should be in there. Their view is that if they spend all their time filling in the detail then they are going to be well over the hour and they are not going to be remunerated. So, if they are going to complete a comprehensive biopsychosocial assessment, that takes at least an hour, and that could be recognised under an item number like that.

CHAIR: I have that. Then we move on to the general access, and you make comment in your submission about young people not accessing Better Access very much, or headspace.

Mr Tanti: That they generally do not access Better Access.

CHAIR: They generally do not access it—or ATAPS, for that matter.

Mr Tanti: No.

CHAIR: And only a handful of headspace centres have an ATAPS worker.

Mr Tanti: That is right.

CHAIR: Then you talk about a different funding model. I get the rationale. How would you see that then working in terms of making Better Access work for young people better—sorry, more appropriately—and improving how it works, or having another system or process, basically, that delivers services for young people?

Mr Tanti: I am not sure that I completely understand your question.

CHAIR: I am trying to work this out. As I said, I can understand that you are saying we should be differentiating young people in terms of accessing GPs for plans.

Mr Tanti: Yes.

CHAIR: I have that. But you also talk in the submission about the fact that young people are not accessing Better Access.

Mr Tanti: Yes.

CHAIR: I presume that is for support services and counselling or psychologists.

Mr Tanti: Yes.

CHAIR: If it is not delivering—and I take your word for it; I am not questioning that, because it makes sense to me—how do you see it working better? We get the plan.

Mr Tanti: Yes.

CHAIR: How do you then see making Better Access work better for young people?

Mr Tanti: I am the CEO of headspace, so I have a particular bias. I think the reason why what we are doing is successful is that we have created youth-friendly environments that are created by young people, so they are actually involved in the look and feel. So young people easily identify with it. I think the reason that Better Access is not accessed by young people is that often it is through general medical practices that they do not necessarily feel comfortable in.

CHAIR: In other words, we get young people to bypass Better Access, essentially, and go to the headspace centres—

Mr Tanti: Yes.

CHAIR: because then they can access a range of services and they start with the plan.

Mr Tanti: That is right.

CHAIR: Okay, I have it. Of course, this inquiry is looking at a funding package—changes to Better Access but also an across-the-board funding package.

Mr Tanti: Yes.

CHAIR: We may need to get some work done on this, but essentially what the government has done, you could say, is take money out of Better Access to put not just into headspace—I am not going to run that argument—but also into EPPIC and other mental health services—flexible packages et cetera. Part of that is reducing it from 18 to 10.

Mr Tanti: Yes.

CHAIR: And is your argument that that is appropriate because young people were not accessing Better Access, so we are taking a chunk of money out of Better Access and putting it into headspace?

Mr Tanti: I—

CHAIR: And I am not trying to put words into your mouth—

Mr Tanti: No, no.

CHAIR: I am trying to understand it because there will now be a group of people that were not being serviced. The problem is there is a group of people that were being serviced and the arguments we are hearing today is that now there is going to be a whole lot of people, 87,000 in fact, who miss out from accessing Better

Access because funding has been taken out in order to deliver services elsewhere. Now I am not asking you to balance, I am just trying to get into my head whether that is a good outcome or whether we need to be injecting more funds on top of, because the argument is very definite, we need to be injecting more funds. Not to gain better access, as hard as it had been, but in order to facilitate access to people that have not been able to get mental health services and support.

Mr Tanti: I will give you my most simplistic view. From my perspective, the increased funding to existing headspace centres and having more headspace centres dotted around the country over the next four years is a good thing, is a good outcome, which is not to say that reduction in Better Access is a good thing. We are very grateful for the additional funds we have received. I think we will see more young people accessing Better Access as a result of establishing more headspace centres. That is probably the simplest way I can put it.

CHAIR: And I think what we will do is get some figures on that number. It will be in the evaluation report. I just do not know it off the top of my head how many young people are accessing Better Access.

Mr Tanti: And I cannot recall, unfortunately.

CHAIR: Okay. And so when you talk about, and I am sorry to harp on this, the different funding model, because in your submission it goes from talking about Better Access to that and that is where I think I was initially confused. You are just talking about, just so I am clear, the number specifically for the plans. Not for anything else?

Mr Tanti: No, just for the plans.

CHAIR: Okay. That is where I was confused. By reading your submission I thought you were arguing for two. One to facilitate more access to Better Access, as well as the headspace funding. But you are saying no, the headspace model is better for young people?

Mr Tanti: That would be my view.

CHAIR: Okay.

Senator MOORE: And you want it augmented with the specialist nurses type program? So that is the other specific recommendation in terms of a changed mental health for young program?

Mr Tanti: Yes, my view is that we have got 30 of these things, we will have 90 of these things. There are a lot of resources in the community, there are a lots of different opportunities with Commonwealth funding and with state funding. My view would be if we can bolt that into something that is recognisable for young people and we can meet the demand out there, and young people do not need to think about where to get help, I think that is a good outcome for the community.

Senator FIERRAVANTI-WELLS: I have just one more question, if I may. One of the terms of reference is the adequacy of mental health funding and services for disadvantaged groups. And amongst that is CALD and Indigenous communities. And given the issues that exist with young people in both those, and of course people with disabilities, but if I could concentrate on the CALD one for the moment. Has headspace done work with the Multicultural Mental Health Australia project?

Mr Tanti: We unfortunately have not done a lot of work with CALD groups. Certainly, the multicultural area, given my background, is a priority for me and it is something I am very interested in. Recently, we have tried to do a lot more work with SBS radio and SBS TV. We do need to work out how we are going to reach those communities. We have set up an ATSI taskforce within headspace that is chaired by one of the board directors and involves Indigenous people from around the country, but it is area we have not really got our teeth into yet.

Senator FIERRAVANTI-WELLS: All right, thank you.

CHAIR: Thank you very much. Did we give you any homework? I think you got away without any homework

Mr Tanti: That is perfect.

CHAIR: I will have to dream up something quickly!

Mr Tanti: That is exactly what I need at the moment.

CHAIR: Thank you very much for your time and as it is appreciated, as is your witnesses time. Thank you.

Mr Tanti: Thank you for your time.

Proceedings suspended from 16:00 to 16:11

O'NEIL, Ms Dawn Marie, AM, Chief Executive Officer, beyondblue

CHAIR: Welcome. You have been before committees before, so I know that you know about parliamentary privilege and protection of witnesses and evidence, but I just want to double-check that you have been given that information.

Ms O'Neil: I have.

CHAIR: The committee reminds witnesses that evidence should address the terms of reference of the committee and that misleading the committee may constitute a contempt. We ask that witnesses avoid making adverse comments against other parties and warns that reflections may prompt the committee to suspend proceedings. The committee may decide to take evidence in camera at any stage and witnesses may also ask to present evidence in camera, which the committee will consider. We would then go into another process.

We have your submission, which we have numbered 171. Would you like to make an opening statement.

Ms O'Neil: Good afternoon, and I apologise for being late. I am not going to repeat what is written in our submission. I just want to highlight a couple of the key points we made, and perhaps elaborate a little more. Then I am sure you will have questions.

First, concerning the terms of reference, the changes to the Better Access initiative, as beyondblue we are supportive largely of those changes and quite positive about them. Thinking about the original intention of the Better Access program, it was established in the first place to provide better access to psychological services. As the evaluation of this program shows, it has indeed done that, which is a very positive thing, but it has not meant better access for everybody. It is very much our belief that the emphasis has to be shifted from where the providers are located to broadening the ATAPS programs so that there is actually better access for all. Obviously, that means targeting services to where people are and being more specific around the types of services and not having a one-size-fits-all type of arrangement, which Better Access is a little bit like. It also means ensuring that people can actually get access to services when they need them.

That leads on to a number of the other questions in your terms of reference about the workforce, the funding for disadvantaged groups and the expansion of ATAPS and how that should all pan out. In brief, it is very much my belief that the ATAPS services need to be expanded much more than they have. The new flexible care packages are very good but they are a tiny drop in the ocean as to what is needed. The program is almost a pilot; it is so small as far as its ability to reach people with severe mental illness. We need to think much more carefully about the stepped care type of model and how we tailor services to reach people with a range of different needs, and not just provide one or two alternatives.

Some of the concerns we have around the flexible care packages through the ATAPS program for those with a severe and persistent mental illness are about the risks of those services not being available in some areas. There will be a demand in some divisions—or Medicare Locals, as they now are—and an expectation that people will have access to those services when there is actually going to be very little there. The other big area of risk is that the state based or community based services will use this as an opportunity to not provide services to some people, that some people will be excluded because of that.

Obviously there is no doubt there are huge opportunities in the online space. I am trying not to repeat what I think everybody has been saying. One of the things we need to think carefully about is how we involve drug and alcohol online services as well into the mental health services. Too often we forget about the co-occurrence and the comorbidities. We know there are a lot of great evidence based online services in the drug and alcohol area. This is an opportunity in the online space for us to work together perhaps better than we have in the face-to-face service area.

There is no question data collection needs to be more effective than it has been in the past. There are opportunities, which I would be happy to share, to do more interesting and exciting things in that area so that we have a better sense of where suicide clusters might occur, where the admissions are happening geographically, where ambulance calls are coming from for attempts and those sorts of things.

Finally, on the National Mental Health Commission, it is a bit hard to respond to that one because no-one really knows just yet what it is going to look like, but obviously it will be a very good thing as long as it is designed well and applied well. One other thing: I have a response to a letter. There was an inquiry that referred to some specific questions from somebody who submitted to the inquiry and we have responded to that. So I will table that at this point in time.

Senator FIERRAVANTI-WELLS: I note the support of one of the few submissions, in light particularly of the evidence we have heard today, where there is a concern that approximately 87,000 people will be disadvantaged. I think that is just an attempt to put a figure on that. Is that a view that you have come to from your own independent analysis or are you just repeating what the government has said? I am surprised because it is the only submission that has said that, apart from the government's.

Ms O'Neil: We were not just repeating the government's line. It has been an independent view. Part of my reading of the evaluation of the Better Access program is that yes, indeed, there are 87,000 people who may not get the level of service that they could otherwise have gotten but it is not that they will not get any service. That is my understanding.

Senator FIERRAVANTI-WELLS: Ms O'Neil, if you do not mind, could you have a look at the transcript of some of the evidence given earlier today. If you want to make any additional comments, that would be helpful.

Ms O'Neil: I have not seen that evidence.

Senator FIERRAVANTI-WELLS: Some of the evidence also given today looks at the inadequacy. There might be more money going into ATAPS but it is robbing Peter to pay Paul. There are going to be issues there about targeting that also. Have you worked with Multicultural Mental Health Australia before it was moved on, if I can put it that way?

Ms O'Neil: Yes, we did. We had a memorandum of understanding and a partnership with Multicultural Mental Health Australia. We provided some funds for some research, which we had to wind up when they wound up.

Senator FIERRAVANTI-WELLS: It worked well?

Ms O'Neil: Yes.

Senator FIERRAVANTI-WELLS: I am not sure if you are aware of some of the issues surrounding their funding. Where are you now getting your CALD services from, if I can put it in those terms?

Ms O'Neil: We had a number of partnerships. beyondblue is not a service provider, so we refer to other service providers. Now we do not have that avenue to refer to, we use some of the multicultural health centres that are more locally based and Melaleuca. We launched a partnership project this week. We partnered with a number of organisations like that to develop some resources for the Afghani community, the Burmese community—

Senator FIERRAVANTI-WELLS: So it is more ad hoc rather than the coordinated approach that you were able to do with MMHA?

Ms O'Neil: Yes. I think we have four or five different partners. It was much easier with MMHA because it was a single point of contact.

Senator FIERRAVANTI-WELLS: Can you elaborate on the free translation and interpreting services?

Ms O'Neil: We operate the beyondblue phone helpline. We have a lot of callers who request translation services. Sometimes they are readily available and work well and sometimes they are a bit patchy. We have invested a lot into translating our own brochures, information and resources.

Senator FIERRAVANTI-WELLS: I have seen some of the work that you have done there.

Ms O'Neil: The one we launched this week was in four different languages. There is a big need. Certain communities where there are fewer resources available—

Senator FIERRAVANTI-WELLS: Do you have some statistics in relation to that?

Ms O'Neil: We would do, but I do not have them on me.

Senator FIERRAVANTI-WELLS: Would you kindly take that on notice?

Ms O'Neil: Yes.

Senator FIERRAVANTI-WELLS: Thanks. You also commented on the national disabilities scheme. Do you want to add any more to that?

Ms O'Neil: Not much more. Really we just want to say that we think it is a very positive move. I understand the complexities around rolling that out. It is going to take some time. Broadening that over time will be a good thing.

Senator FIERRAVANTI-WELLS: How do you see the national mental health commission? I have asked this question all day, so I am interested to hear your views in relation to it. At the moment there are a few commissioners tucked away in the Prime Minister's office. Is that your idea of what a good national mental health commission should be?

Ms O'Neil: I have not seen what they have been doing tucked away in that office, so it depends what they actually—

Senator FIERRAVANTI-WELLS: It is not much.

Ms O'Neil: It is new. It is early days.

Senator FIERRAVANTI-WELLS: But the concept.

CHAIR: It hasn't started yet.

Senator FIERRAVANTI-WELLS: I am just asking the view. There have been views expressed on it. I am just asking if beyondblue has a view of what our national mental health commission should look like.

Ms O'Neil: Our vision would be an entity that would be able to gather information and monitor the performance of mental health service delivery in Australia. That is a central point. Not every little piece of data, obviously—that is a very tall order—but there has been a lot invested in gathering information. There is a lot invested in gathering information at the community level and at the state level, but the analysis of that data and actually holding people to account as to how effective it is, I do not think we have done that very well in Australia across a whole lot of areas, but particularly in mental health. My hope for the commission is that it would look at the data that is available, do good analysis, monitor and hold to account.

Senator FIERRAVANTI-WELLS: Independent of government?

Ms O'Neil: Preferably independent would be the ideal, absolutely, but we are grateful there is such a thing as a commission at this point. But, yes, independent would be the ideal.

Senator FIERRAVANTI-WELLS: Are you contributing to some of the work that is being done here in Victoria in relation to looking at mental health? In New South Wales the new government is setting up a mental health commission and in WA there is a mental health commission. There is work being done in Victoria. Are you contributing or making submissions or are part of that process?

Ms O'Neil: Yes, we are, but perhaps not as vigorously as some of the local service providers. But, yes, we are.

Senator FIERRAVANTI-WELLS: Thank you.

CHAIR: I will go to you on a second, Senator Moore. I just wanted to follow up on the commission. You said preferably independent. All those things you listed for what a commission should look like, do you think the structure that is proposed under PM&C will be able to deliver your ideal of what a commission should deliver?

Ms O'Neil: In some ways it depends on how it is structured within PM&C, too, but I think there will be challenges for that level of independence to occur perhaps as we might like. One of the advantages, I guess, of the federated system is that at a federal level there is going to be a level of independence and scrutiny across all of the states and comparing what is happening on the ground that you would not get necessarily if it were located in any particular state. But if it were outside of government, you may not get access to as much information. That is the trade-off, I guess.

CHAIR: Given the structure and given that it is in PM&C, do you have any suggestions that we could make to ensure that it is as independent as possible?

Ms O'Neil: I think transparency around the data that is being collected, what is being analysed to find out—so really clear terms of reference around what data is going to be looked at; target setting—I know we have been very, very loath in Australia to set outcome targets in any of the mental health plans—actually setting some targets around what we are trying to achieve, what we are trying to change; and then monitoring what happens to actually see whether there is a change. Is there a change in help seeking, is a change on impacting disability, is there a change on awareness levels or de-stigmatisation, is there a change in consumer and carer involvement in planning at the local level, is there a change in experience for consumers? That last is key. Some high-level things and then changes in suicide rates. All of those things we know are big indicators as to whether our system is working well. Do people get access, how long do they have to wait, is the experience they have the time a useful one? We gather all of that information but we do not really analyse it and we certainly do not hold ourselves to account particularly well.

CHAIR: Thank you.

Senator MOORE: Ms O'Neil, your submission is the only one I have found that has mentioned gay and lesbian issues. I am really pleased that it is in there. Do you want to put something on the record more than just what you put in the written submission about the importance of this area?

Ms O'Neil: Yes. I think it is an incredibly important area. We know that people from the GLBTI community experience more discrimination and more stigmatising attitudes right across the board but also in mental health

services, particularly in community, and as a result of that discrimination they often experience poorer mental health. I think it is incredibly important that all the services are very aware of that. I think there is a real danger, in talking about the GLBTI community and mental health, that there is an assumption made that, because of people's sexual orientation, there is a co-occurrence of mental illness. It is very important that everyone understands that it is because of the stigma and because of the discrimination that those impacts are higher—similarly for people who are bullied or experience a trauma. It is the same result.

Senator MOORE: The other question I have is about ATAPS. The government's proposal is that extra funding will go into ATAPS to pick up some of the people's issues, particularly those that need long-term counselling. We had a discussion with the previous witness today about people who have chronic mental health issues. You support the growth in ATAPS but you make the comment, just on one line, that there needs to be some consideration of administration issues. I would like to know what you mean by that.

Ms O'Neil: I think there will be very high expectations that people are going to have access to these sorts of services for longer term needs. I know that the ATAPS funding is quite limited and is going to be widely dispersed, so there are going to be high expectations and probably disappointment. I think that we really need to come up with a much better set of services or a service model, whether it is through ATAPS or through some other mechanism, for the longer term needs. It is a very specific different set of needs for chronic mental illness. I do not think we have got it right yet and I think we have got to come up with some new models and we need to roll them out and resource them adequately—out of hospital, in community.

Senator FIERRAVANTI-WELLS: Because of the work that beyondblue do, can I just ask you a question in relation to suicide statistics. I think we just do not have a clear picture of them. When you look at even the ABS statistics, they talk about 280,000 contemplating suicide, and then we have statistics showing only 2,000 suicides in Australia. Do you think it is time for a change in the coronial reporting structure? I know it is a difficult issue and carries with it a whole lot of other things, but do you have any thoughts in relation to that?

Ms O'Neil: I do have a lot of thoughts in relation to this!

CHAIR: Just for the record, it is an area we traversed extensively in the suicide inquiry.

Senator FIERRAVANTI-WELLS: I know, but I asked in the context of the service delivery. My memory does not serve me—and yours does because you worked directly on it and I sort of only came in at the end—but was there a recommendation made in relation to—

CHAIR: Yes—

Senator FIERRAVANTI-WELLS: Oh, well, I take that back.

CHAIR: But it was in fact an issue I was going to raise, because I think it is part of the package, particularly when Ms O'Neil raised the issue earlier about data. I was not having a go; I was just saying that that is the context.

Ms O'Neil: I think it is a good issue to raise, because suicide is obviously the worst possible outcome of a mental illness, so there is no question that these are related issues. The data collection at the moment is not adequate for us to respond effectively. The coronial data collection system, I think, is one way of making some changes. There is no question there is a significant amount of work to be done there. But there are some other things we could do to better collect data to enable us to respond more effectively at the local level. For example, at this point it is my understanding that there is not consistency in the way police record the data. There are some quite simple things on the forms that they fill in that could be fixed up. That could be done relatively simply, you would think. When I say 'relatively simply', I mean in relative terms. Those forms could be collated and that information gathered separately from the coronial system. One of the problems with just relying on the coronial system to get suicide data is that it has particular constraints around how it can confirm intent of death—so what someone's intent was when they suicided or made an attempt, or what the cause of death was. That is the word I am looking for: the cause of death.

Senator FIERRAVANTI-WELLS: And through the police system there is a greater anonymity, if I can put it that way—

Ms O'Neil: Correct.

Senator FIERRAVANTI-WELLS: which is always, in a coronial situation, more complex.

Ms O'Neil: The reason I was a little late in getting here is that I had been talking to Turning Point, which is the drug and alcohol service down here. They have all of the ambulance data. Victoria is the only state at this point in time that collects all of the ambulance data and analyses it. In that ambulance data you can analyse the reason why the collection occurred or the call-out was made, and often it is for a suicide attempt. You can then track that data back to where the pick-up occurred; you can actually geomap it back to that. That would not be

that complex or expensive a project to do. We could get that ambulance data for all of Australia and assess, perhaps, where suicide clusters are occurring. They are able to report on that within two months of collecting the data—much closer to real time. That is another whole area where we could look at other ways of getting the data and the information—

Senator FIERRAVANTI-WELLS: More neutralised.

Ms O'Neil: More neutralised. That is right. We are looking at attempts then—in Australia we do not do gather good information about attempts; it is very patchy—and it is closer to real time, so we can see where they occur. Perhaps 100 or more attempts might occur in a period.

CHAIR: You are getting sufficient highlight clusters.

Ms O'Neil: Yes, you are getting highlight clusters early on. There are a range of things we need to do, not just in the coronial data collection system. We need to be a bit creative around that.

CHAIR: If you have some more thoughts on that then that would be useful. Thank you.

Senator ADAMS: In your submission, you talk about workforce issues and the national shortage of clinical psychologists. I am inferring that this might impact on the model of health professionals assisting rural and remote communities. Do you think that clinical psychologists are the most suitable people to be dealing with the issues in rural and remote communities?

Ms O'Neil: Controversially, no; not necessarily. I know that will not make us all that popular. My understanding of the evidence is that certain therapeutic interventions, like cognitive behavioural therapy, can be delivered by people with a range of training and skills. In rural and regional Australia particularly, where we know there is a lower level of people with clinical psychological training, there is a huge opportunity to train other individuals, and they do not necessarily have to be health professionals. There is strong evidence coming from the United Kingdom, where this has been rolled out all across the country. They have a one-year training course involving training on a skills basis, training people in cognitive behavioural therapy—so low-intensive therapeutic interventions—and getting as good outcomes as the clinical psychology face-to-face interventions. So we need to think creatively about our workforce. There are a lot of people who live in rural and regional Australia who could be trained to deliver CBT and provide those services that are currently not available. They can also be done online and by telephone. I do not think we are utilising those access points as effectively as we could.

Senator ADAMS: As far as remuneration goes, how would we get on there?

Ms O'Neil: That sort of low intensity workforce could be funded through and a tax program, ostensibly, where you could therefore determine where it would be located and how many workers would be there through a division process or some other way.

CHAIR: I have another question around ATAPS, although I think I may be giving you a question on notice. We have had quite a lot of evidence today around not only the admin issues which you touched on but also around the different ways that a division can choose to deliver it. For example, we had Northeast Health Wangaratta in today, and they were saying that they budget theirs for the whole year, whereas some of the psychologists said earlier this morning that, because it is capped, a division could use it all up in the first six months and then they would basically have no services. That puts a question mark over the effectiveness of the extra funding going into ATAPS and whether we will see that go the same way. You have said here that you support the additional funding for more people, but I suppose the evidence we have heard this morning puts a question mark over the effectiveness of that.

Would you mind having a look at some of the evidence that we have received and giving us some of your thoughts? I know Senator Fierravanti-Wells and Senator Moore were touching on this earlier. Could you give us your thoughts on those comments and also give us any suggestions about what could be put in place to help that process to make sure that does not happen so that the increased funding is effective?

Ms O'Neil: I would be happy to do that.

CHAIR: I am now going to ask something a bit controversial, though I do not mean to be. We have had a lot of controversial evidence this morning with different opinions from different organisations.

Senator FIERRAVANTI-WELLS: That is diplomatic!

CHAIR: I am trying to be diplomatic! One of them was about two tiers. The comments that were made were that that means that you get people going to the top 20 percent when they are going for Better Access and that that means, because there is a two-tiered process, that Better Access is not applying value for money. I am not asking you to comment on—

Ms O'Neil: When you say 20 percent, what do you mean?

CHAIR: What we have said is that, because of the two-tiered process, the clinical psychologists are in the top 20 percent and that people want to go to them because they get the higher rebate. Unless you want to, I am not asking you to give an opinion on that—it is not fair—but my question is: have you heard people complain about that in terms of the value for money and the fact that the two-tiered system means that we are not getting the best value for money out of Better Access that we could be?

Ms O'Neil: We have more than 1,000 consumers in a consumer group that informs beyondblue in what we do—our blueVoices group—and we regularly contact them and ask them about these sorts of issues. I know we did ask them about that question. I do not have that information in front of me, but I would be happy to provide that on notice—that consumer perspective. I am assuming you are talking about consumer perspective.

CHAIR: What you have heard through your organisation. But a consumer perspective would also be extremely valuable on that, yes.

Ms O'Neil: We can definitely provide you with that.

Senator FIERRAVANTI-WELLS: You will see the evidence today.

Ms O'Neil: So that will help me understand—

CHAIR: That will help to clarify what we are after.

Ms O'Neil: what the question is, yes.

CHAIR: Anything that you can add there I think would be extremely valuable for us.

Ms O'Neil: We certainly put out to them when these changes happen—'What does this mean for you and what is your perspective on it?' Of course, we always get a range of views, and that does guide what we submit and has guided what we have submitted. I will provide more detail on that in response to that question.

CHAIR: Thank you. In closing, because we did not so this morning, I would like to say that we have had over 1,000 submissions to this inquiry. That means that we have had a lot of processing to do, so not all submissions are up on the website yet, and we are trying as hard as we can to process them. The fact that we have had over 1,000 submissions shows that people are obviously taking a keen interest in this inquiry. Thank you, Ms O'Neil, and thanks to all witnesses who have appeared today. We will reconvene this committee on 5 September in Canberra.

Committee adjourned at 16:44