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**Senate Committee on Mental Health Funding, 2011
Personal Submission**

Re: the government's intention to cut funding for the so-far successful Better Access to Mental Health scheme

Apparently the money saved is supposed to be redirected into more effective alternate services for 'more severe' mental health problems. I don't think the government understands what psychologists are actually already doing in our servicing of Medicare patients, and I'd like to offer the following information based on my practice:

I have been doing the Mental Health Care Plans (Better Access) since their inception and:

- about 80% of my practice currently services people with MHC Plans.
- 45- 50% of these are bulk billed, which I offer to pensioners and people with a health care card
- another 10-20% would be low-gap or no-gap services for people on low incomes or those temporarily affected by e.g. significant health problems or the recent floods in Queensland.

Treatment Availability:

At least half my current clients would *not* have been able to afford any psychological treatment for their disorders without the Better Access Scheme. They'd have been relying on drugs and whatever counselling is offered by their GP or psychiatrist. Many GPs and Psychiatrists don't offer talking therapy at all, and most doctors who do offer it, do so opportunistically and within time limits, because of the volume of their other work.

The people I'm treating:

At least 60% of the clients referred to me are severely or extremely severely affected by psychological disorder at the outset (measured by Kessler 10 & the Depression Anxiety and Stress Scales), mostly symptoms of mood disorders i.e. depression and anxiety.

At this level, mood disorder typically affects both a person's functioning in life and their physical health.

I'd say more than half have additional diagnoses e.g. Post- Traumatic Stress Disorder, stress-related physical disorders, abuse histories leading to complex PTSD, developmental disorders (Aspergers, ADHD etc), eating or substance abuse disorders.

Most severe mood disorder clients have things in their past that make them recurrently vulnerable and that really need sorting out to prevent recurrent relapses.

There is a noticeable correlation between symptom severity and the need for bulk billing – poor people are much more likely to have had backgrounds that predispose them to chronic untreated mental disorders, and their mental disorders in turn exacerbate their poverty.

The treatment they receive under Mental Health Care Plans:

People get a thorough assessment and feedback on the nature of their problem and what we can do about it. They take part in putting together a treatment plan, with options and recommendations as to how things are addressed and in what order. Their GP gets feedback on this assessment and plan.

Treatment is on a regular schedule, it is progressive and we use a lot of Cognitive Behaviour Therapy (CBT) which is a psychological treatment of choice for depression and anxiety. CBT works by the consistent retraining of the mind – it's like antibiotics, if you do a few sessions then stop, the gains are quickly lost. The gains from CBT have to become established and the person needs to become proficient in using CBT techniques so that they can support their ongoing recovery with self-help, once their plan is finished. The plan is reviewed by the GP after 6 sessions, after a progress report from the psychologist. The patient leaves treatment with a personal relapse-prevention plan in place and their GP gets a final report on outcomes.

Sessions needed:

People whose original symptoms are mild to moderate tend to reach an established and sustainable recovery in between 6 and 12 sessions, depending on the complicating events and diagnoses.

With people referred at the stage when symptoms have become severe or extremely severe, they tend to be only partially recovered after 12 sessions. Patients with very severe symptoms and long-term additional diagnoses often don't start really surfacing until 12+ sessions. Once people with severe symptoms realise their therapy is working, the gains often improve rapidly and this point of confidence allows self-help to begin.

Outcomes:

In my practice most people with mild/moderate symptoms end up with none or very mild symptoms. Most people with severe/extremely severe symptoms end up with none, mild or moderate symptoms.

I hope you can understand why I say that cutting the Better Access sessions back from 12-18 to 10 is going to entail a frustrating waste of time, effort and public money in close to half my patients. We're going to achieve so much and then have to stop, then their GP has to start again with a symptomatic patient, a half-completed treatment plan and no-one available to finish it. Patients with money and private cover may be able to keep having their sessions but those who are bulk billed can't and they will go without.

Please accept my assurance that we are not over-servicing here – I regularly turn people away because my practice is so full. It takes many hours of unpaid admin and report/letter writing to support the Better Access service, and I don't mind that - I'm just glad to see people recovering their mental wellbeing. I think most psychologists feel the same.

Re: the 2-tier Rebate system for psychologists

Medicare's study findings have clearly shown that psychologists with ordinary registration are doing every bit as good a job in terms of overall Better Access outcomes as those who have clinical level registration. I'm in the position of having done both state registration and then later a clinical masters, and I'd say that whilst my rego training supplied me with most of my everyday psychological skills, I'm still glad I did the Masters course because of the extra training in the more severe and non-negotiable eventualities such as psychiatric illness, medication, neuropsychology, minimal brain damage and developmental disorders, and also the extra experience in understanding inpatient treatment systems, case management and liaising with doctors. I know much more now about when to refer on, who to liaise with and how to do it.

I'm not saying that clinically registered psychologists should necessarily be paid more than regular psychologists, I can see why many people object to the 2-tier system and it's up to Medicare to decide if these extra skills are useful or not. All I would say is that they don't pay airline pilots the majestic salaries they do for the hours they spend watching the autopilot fly the plane - they pay them for knowing what to do when the wheels fall off.

Whatever is decided about the rebate system, can I just add that I believe the terms '*endorsed*' and '*unendorsed*' should **not** be used in presenting psychologists to the public. The work '*unendorsed*' has a perjorative flavour that makes the majority of psychologists sound like they're of unreliable quality and are not recommended, which is very unfair to them and to the profession. This may not be within the scope of this enquiry, but if it is, I do hope that a more accurate and respectful terminology can be found to describe this system.

Many thanks for your time, I hope you can help.
Kind regards

Anne Etchells, Clinical Psychologist