

---

**Carol Strentfield**  
**Psychologist**

BA(Psych) MEdPsych AsMAPS

---

ABN 66 780 535 330  
Medicare Provider Number  
2790143K

Submission to the Commonwealth Funding and Administration of Mental  
Health Services Senate Committee Inquiry

As a Psychologist with a Master of Educational and Developmental Psychology, and not a Clinical Psychology degree, who works with people of all ages but predominantly with children and adolescents, there are a number of comments I would like to put before this Committee for consideration. These comments will be dealt with in the following order:

- 1) The proposed reduction in the number of sessions provided for clients accessing the Better Access Initiative;
- 2) The two-tiered fee reimbursement system between Clinical Psychologists and other Psychologists, with an illustrative example with reference to the inadequacies of the current system as it pertains to the treatment of children and adolescents;
- 3) Funding for people with disabilities;
- 4) The administration of the current system.

1) *The proposed reduction in the number of sessions provided for clients accessing Better Access Initiative:*

Ideally, the number of sessions available for refundable access should be tied to need rather than to an arbitrary number of sessions per year. People and their situations vary enormously both in the type of problems with which they present and their capacity to respond to needed change. The establishment of rapport between therapist and client alone takes different lengths of time.

If, however, for economic reasons it is thought necessary to limit the number of sessions available, the current system of twelve sessions per year, with an additional six extraordinary sessions, if needed, seems to suit well. As it is frequently the case, clients in crisis require more frequent sessions at the beginning of the therapeutic treatment program, with a wider spacing of the sessions as treatment progresses, twelve sessions allow for more frequent visits initially with a longer maintenance and support period which ensures the prevention of relapse and the sustained application of learned strategies. To cut the allocation to ten sessions reduces this maintenance period and places more pressure on the Psychologist to achieve good outcomes within a limited period of time. It is false economy and counter-productive to spend money establishing a positive therapeutic direction only to have it fail because of lack of maintenance.

Some illnesses and issues require longer than one year to overcome, or at least to ameliorate. Ten sessions does not allow even one session per calendar month. For long-term assistance this would be insufficient. Intense emotional distress or overwhelming situations, cannot always wait the required number of months until the next allocation becomes available. It would seem to be common sense for treatment to be available when needed rather than on a prescribed schedule.

2) *The two-tiered fee reimbursement system between Clinical Psychologists and other Psychologists, with an illustrative example with reference to the inadequacies of the current system as it pertains to the treatment of children and adolescents:*

The current division of funding between Clinical Psychologists and other Psychologists would appear to be based on a misunderstanding of the training and qualifications of Psychologists. There is also some confusion over what qualifies a client for Better Access sessions, i.e. what is a 'mental illness'. These two matters cause considerable unwarranted inequity within the profession; reduces the availability of appropriate expertise for some clients; and can make running a private practice, while trying to be available to poorer clients through bulk-billing, virtually impossible.

The current rationale upon which the division is based seems to be based on an assumption that Clinical Psychologists are the ones trained to treat 'mental illness'. What Medicare uses to validate access is a requirement to be 'diagnosed with a mental illness'. The *Diagnostic and Statistical Manual – IV – TR of Mental Disorders (DSM-IV-TR Mental Disorders)* is what is used by Psychologists to diagnose the problems with which clients may present. Exactly how it corresponds to the medical profession's ICD-10, I am not sure. However, there are many diagnoses within the DSM-IV, such as 315 *Childhood Disorders: Learning and Motor Skills Disorders*, which would not be considered a 'mental illness' but most certainly often cause very significant distress and disruption to a child's development, and dysfunction in the home and school. The

subsequent possibility of the formation of a depressive or anxiety disorder, alcohol and drug dependence, suicide, conduct disorder, identity problems, truancy, criminal activity, and final residence in detoxification facilities, the Child Safety Department, and the Correctional Services Department, are very real and serious outcomes which everyone must be anxious to prevent. Proper assessment, with recommendations to home and school, and treatment for inappropriate emotional/behavioural reactions, are very valid therapeutic needs and goals, but are very poorly dealt with by the present two-tiered system and 'mental illness' requirement. To refer such a child, Doctors are placed in an invidious position of having to diagnose a 'mental illness', usually Attention-Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Asperger's Syndrome, Anxiety Disorder or Depression to fit in with this requirement. These may, or may not, be appropriate. On the other hand, once diagnosed, the most appropriate Psychologist to refer to, would be an Educational and Developmental Psychologist, not necessarily a Clinical Psychologist. Many Clinical Psychologists do not work with children, do not have the required developmental or educational knowledge to cover the possible needs, nor the equipment, strategies and skills to work with the under-eighteens. However, when the rebate for a fifty minute hour is approximately \$57, no rebate available at all for parent consultations without the child present, and none at all for assessments, then parents and children, as well as the Psychologist, are simply disadvantaged in every way by the current system. It is not possible for a child or adolescent to give an accurate background history, therefore a parent interview is essential. Having the child present is often simply inappropriate and unhelpful. Also, an accurate assessment is essential to understand what is causing the problems and to plan the treatment, much of which is given to the parent as advice on parenting. Given the enormous financial cost of keeping a person incarcerated for criminal activity (a very high proportion of inmates having literacy and numeracy problems and anger management/self-esteem problems), and the even greater personal and social cost to the community, one would think that these oversights, and misunderstanding, would be rectified.

### *3) Funding for people with disabilities:*

There is a mention in the terms of reference that funding for people with disabilities would be considered. As the impact of poor literacy and numeracy is considerable, as outlined briefly in item (2) it would be important for the Committee to consider the mental health and developmental issues that arise from disabilities in literacy and numeracy. It is inappropriate to relegate such outcomes to the purview of education exclusively, although obviously they overlap. Personnel in the education system are not trained in diagnosis, and there are many reasons for literacy and numeracy problems which require differential planning and treatment. Nor are there enough educational personnel to carry out the assessments required. With Guidance Officer ratios of something like 1,200 to 1,500 children to 1 Guidance Officer, who not only carries out assessments but counselling and treatment planning, also, it is poor management of available expertise to leave all such assessments as their sphere of responsibility. When Educational and Developmental Psychologists are trained for this and more, it seems a waste of personnel, and another disadvantage for parents and children, not to give greater support through the Better Access Initiative.

#### 4) *The administration of the current system:*

While the institution of the Better Access Initiative has been enormously helpful for the general public to access help with psychological problems, the method under which it is administered is cumbersome and confusing. It is also unnecessarily time consuming and causes clients extra, unnecessary expense. There are problems in the following areas:

a) There is lack of knowledge that a Paediatrician's or Psychiatrist's referral to Better Access is sufficient and that a further GP 2710 referral is not necessary. When clients do not understand this, they go to considerable additional expense seeing a GP. When Medicare personnel do not understand this, the client is denied a refund.

b) Differing item numbers, as required by Medicare for referral through a Paediatrician, lead to much confusion as the Doctor does not always supply the item number to the Psychologist. As there are different numbers for Pervasive Developmental Disorders and for all other diagnoses, this can leave the Psychologist not knowing what corresponding number to use on the client's invoices. Since the refund from Medicare varies between the two diagnostic categories, this is important. The number of visits allowed, plus the availability of parent discussions and diagnostic/planning assessments, makes the PDD diagnosis completely different to administer for the Psychologist, and has significant financial implications, and service availability implications, for the client, also.

c) The requirement for review by the referring Doctor after six sessions can be cumbersome and is time-consuming. Certainly, it is necessary for the referring Doctor to be kept abreast of what is happening, however, when the client has to return to the Doctor for permission for the next group of sessions, and cannot see the Psychologist until s/he has received the permission letter, there can often be considerable delay in this occurring. A client's need does not vanish while the paperwork is done. When the referring Doctor is a Paediatrician who has a three month waiting list, or longer in the country, then this is simply not practical.

The fact that a GP's permission for additional sessions needs to be sought seems an anomaly in the system. Doctors refer patients for psychological treatment because they do not have the expertise to provide these services. It is odd that they are then expected to approve or disapprove continuation of the very services the necessity of which they are not qualified to evaluate. There seems to be a lack of acceptance of the training, expertise and professionalism of Psychologists by this system.

Keeping track of how many sessions a client has had, how many they are entitled to, whether the letters have been written and received, and the clients having the funds necessary for the doctor's visits, is an administrative burden that could, and should, be simplified.

d) It is often the case that a poor client can cover the cost of the gap for a service but is unable to find the initial fee, then claim the refund. There seems to be no justification for insisting that the client pay the whole fee and then claim the refund, when it would be possible for a Psychologist to bill Medicare directly and claim the gap from the client. Since the refund for a non-Clinical Psychologist is too low to sustain a private practice through bulk-billing, it makes it very difficult, if not impossible, for the very people who are Medicare's most immediate responsibility, to access Psychologists' help. Since there is no difference in the amount paid, either by the client or by Medicare, there seems no

justification for the present system, which merely disadvantages the client and makes it very difficult to run a practice which includes poor clients.

*Conclusion:*

It would seem to be important for the Senate Committee to consider not only the economic impact of the Better Access Initiative on the Budget but to do a careful, wider costs/benefits analysis, instead. The costs/benefits analysis with relation to the provision of mental health services through available private practitioners has obvious significant impact on the budgets of many other personnel and departments, such as: hospitals and general practitioner access, Centrelink payments, Workers' Compensation claims, work place healthy functioning, educational provision, correctional services, children's services, community mental health services, court systems, pharmaceutical services, road safety, etc. The loss of personal health through depression and anxiety, and addiction disorders, alone is enormous. The impact through individuals on families, children's health, loss of income and therefore the flow-on through taxation to the community, quite apart from personal contribution to community living and participation, would imply that it is wise to expend as much as is necessary to ensure maximum health, to be able to minimise expenditure later in less productive institutions whose job it is to repair damage that might have been prevented.

Yours sincerely

Carol Streatfield  
BA, MEdPsych, AssocMAPS