

3rd August 2011

Senate Inquiry into Mental Health Services

To whom it may concern,

I am writing to you as a concerned Psychologist (Clinical) and in response to my understanding that the Senate has agreed to establish a Senate Inquiry into the funding and administration of mental health services in Australia. I thank you for this. I also understand that the parameters of the Inquiry are quite far reaching. This letter addresses two issues which I consider are of importance.

1. Proposed Changes to the Better Access to Mental Health Care Initiative

In relation to the proposed changes to the Better Access to Mental Health Care Initiative, I have significant concerns about the proposed amendments, and specifically the proposal to reduce the number of Better Access funded sessions from a maximum of 18 per Calendar year, to a maximum of 10.

It is my understanding that very few, if any, psychological interventions advocate for less than 12 sessions of individual therapy. For instance it is my understanding that

- Cognitive Processing Therapy (CPT), an evidenced based treatment for Post Traumatic Stress Disorder (PTSD) is manualised for 12 sessions of treatment,
- Behavioural Activation (BA), an evidence based treatment for Depression, requires more than 12 sessions,
- Cognitive Therapy treatments for Anxiety (see for example Wells, 1997) typically require between 12 and 16 sessions.

NB I am talking about Evidence Based Therapies which have each received rigorous evaluations as to their effectiveness and efficacy in treating the conditions targeted. It is also my clinical experience that many clients, once referred, experience a change in circumstance during therapy that negatively affects their recovery. Furthermore many clients have more than one issue that they are grappling with and require extensive assistance.

Therefore, the Governments' proposal to reduce the number of Medicare rebated individual therapy sessions to 10 per calendar year will, I suspect, see a growing number of clients receiving inadequate services. Furthermore, in addition to my concern about the benefits for the individuals referred, I also suspect that any decision to reduce the number of sessions available may well also impact negatively on society and the economy in general. For instance, there remains the real potential that clients ineffectively treated will remain unable to work thus necessitating their reliance on welfare, and may well also see them requiring extra services the following year.

Clinically, I also understand that the Government based their proposal on “a survey of just 1350 patients and 300 Better Access services providers - out of a total 2 million patients and 18,000 providers involved in the service thus far”. I also understand that their justification also related to a belief that the “average” number of visits under the plan was just five. I cannot understand how this is either a representative sample, or indeed how they established an average length of visits as 5. I do not know of any clinician where this would be the case. In fact I query whether these clients COMPLETED or LEFT therapy (ie terminated care prematurely). Should the latter be counted among the numbers quoted, this truly gives an artificial impression.

In my opinion the redirection of monies, which I suspect is what is planned, is not a good use of tax payers money, particularly when it is my understanding that a recent review of the CURRENT Better Access arrangement was favourable. I would also like to add that whilst I support Early Intervention as a general principle it is my belief and experience that first episodes, and indeed subsequent episodes, of mental illness are not restricted to the adolescent and young adult populations and that therefore services to the adult population need protection.

2. The Two-Tiered Medicare Rebate System for Psychologists

I am also aware that the Inquiry will address the “*the two-tiered Medicare rebate system for psychologists*”. Firstly, I declare that I am registered with Medicare as able to offer Specialist Clinical Psychology Services. I earned the right to do this. That is, after I completed my degree, I then entered into a stringent supervision arrangement to complete my training. This involved greater levels of skill development and knowledge. More work. I did so willingly, and because I wanted to become the most skilled clinician I could be. I am aware that some would suggest that this should not be considered, however that level of training in my opinion must be recognised, particularly given the clinical work that I am asked to do.

To elaborate. My area of specialisation is that of Psychosis or Psychotic Disorders eg Schizophrenia, Schizoaffective disorder, Drug induced psychosis etc. My practice also includes those affected by Bipolar Affective Disorder or those with enduring personality issues and other co-morbid concerns. The level of skill that I require to understand, treat and assist those with these disorders, or mix of disorders, is not the same as the level of skill required to treat high prevalence disorders such as depression alone. It requires an understanding of a range of therapy and assessment techniques that I need to apply as clinically indicated for the individual clients that present. As I say to them, ‘clients aint clients’ and ‘one size does not fit all’. I should add that in Adelaide, I am one of only a very few psychologists that systematically offer psychological treatment to people with these concerns. My concern about the discussion of two-tiered psychology (and arguments against this) is therefore two fold.

One, the level of expertise that I require to offer this treatment is substantial and intricate and needs to be recognised. I note that “In 1989, the Management Advisory Service to the NHS differentiated the health care professions according to skill levels” and stipulated that “Level 3 - Activities which require specialist psychological intervention, in circumstances where there are deep-rooted underlying influences, or which call for the discretionary capacity to draw on a multiple theoretical base, to devise an individually tailored strategy for a complex presenting problem. Flexibility to adapt and combine approaches is the key to competence at this level which comes from a broad, thorough and sophisticated understanding of the various psychological theories”. This service then established that “it is the skills required for level 3 activities, entailing flexible and generic knowledge and application of psychology, which distinguishes clinical psychologists...”.

I would perhaps also point out that specialists from other professions are recognised and treated according to their level of skill, training and knowledge. EG specialist doctors such as

gynaecologists, Psychiatrists, Oncologists etc. Their level of advanced training is recognised. So should mine be.

Secondly, and more pragmatically. At this time, I offer Bulk-Billing services to clients on Concession, FT students, Disability Support Pensioners etc. In reality the majority of my clients, given their complex histories and disorders, fit this criteria. NB The Recommended Fee for psychological treatment is currently \$218; the scheduled fee under Medicare for a Specialist Psychologist is currently \$119.80. Despite this gross and extraordinary difference I still offer Bulk-Billing, because I want my service to be available to as many as possible. Mental illness does not discriminate against the poor.

Should you reduce my rebate by trivialising my skills, I will simply be unable to do this and my business will likely be unsustainable. Whilst I cannot deny that I am concerned in part for my own wellbeing and that of my family, I am also worried because it will mean that many of my clients will be unable to continue therapy; either because I am no longer in practice or because they can't afford the gap payment. I shudder to think about the impact on them. Many of them have tried the Public Mental health service and did not succeed. Besides, it is my experience having worked in the public mental health sector that the system won't be able to take the influx of clients anyway or offer appropriate treatment. This will again mean that many of these damaged, vulnerable Australians will not get the level of treatment they deserve.

I could continue with these arguments, but won't. I urge the Senate to consider this carefully. This is NOT about money, or at least it shouldn't be. This is about welfare and wellbeing and giving our fellow Australians their right to access specialised services. It is also about respect and a right that skilled clinicians have to expect that if they have been prepared to diligently and conscientiously apply themselves to their profession, they will be rewarded according to their level of skill and training.

I would be happy to make myself available to provide further information should this prove useful.

Yours sincerely /

Kathleen Marksfield
Psychologist (MAPS)