1 August 2011

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

Re: Commonwealth Funding and Administration of Mental Health Services

Dear Committee

I write regarding the Senate inquiry into mental health funding.

I am endorsed, and practice, as a Counselling Psychologist, under AHPRA guidelines. I have been working in private practice since 2002 and work as the principal psychologist within a team of 4 psychologists.

. I have provided assessment and treatment to patients with varied presentations, many of them with complex psychological symptoms.

Prior to working in private practice, I worked in an non-government organisation (NGO), for 3 years, providing mental health treatments to people living with complex mental health (and medical) presentations.

In my 11 years of experience working as a Counselling Psychologist, I have been well-positioned and trained to provide the highest level of expertise in the assessment and treatment of mild, moderate, and severe mental health disorders.

Through my work at the NGO, I was often presented with cases wherein patients reported and demonstrated extraordinarily complex symptoms:

a) the medical and psychological aspects of living with HIV and/or Hepatitis C,
b) the psychiatric and psychological side-effects of anti-retroviral medications (including dementia),
c) the depressive realism of stigma around these medical conditions
d) the anxiety surrounding quality of life
e) the isolation within society (both homosexual and heterosexual)
f) high-risk sexual behaviour
g) substance use/abuse
h) poor self-esteem
i) dysfunctional attachment in childhood and adulthood
j) personality disorders
k) somatoform disorders

For those not living with HIV/Hepatitis C, the presenting issues were often the same, but may have also included issues relating to complex cultural, religious, sexual, and social factors.

Through my work in private practice, I have undertaken psychological assessments, and delivered treatments, for people with the following mild, moderate, and severe diagnoses (often times, including concurrent diagnoses):

a) mood disorders
b) anxiety disorders (including trauma-based)

c) personality disorders
d) eating disorders
e) somatoform disorders
f) substance abuse disorders
g) psychotic disorders
h) relationship dysfunction (families, couples, workplace)
i) adjustment disorders
j) dissociative disorders
k) gender identity disorders
l) aspergers and autism spectrum disorders
m) workplace injury, and
n) pain management

These patients were all non-inpatient presentations, referred from GPs in primary health care settings. To date, I have seen more than 3000 patients, and I have had extensive positive feedback from the patients themselves, GPs, psychiatrists, and other allied health professionals relating to the quality of my interventions.

This would not have been possible without my extensive training at **Macquarie University, through the Masters of Counselling Psychology program (following my undergraduate Honours degree in Psychology at the University of Sydney),** wherein I undertook extensive study in the psychopathology of child and adult disorders, assessment and formulation techniques using ICD-10 and DSM-IV-TR measures, psychopharmacology training, psychodynamic and psychoanalytical training, extensive training in treatment approaches such as CBT, IPT, DBT, group therapy, schema-based, and ACT models, cultural, indigenous, and special population issues, non-inpatient and inpatient internships, and professional development training (ethics, client-therapist dynamics, and private practice management). I have continued my professional training with numerous attendances at conferences and workshops every year.

I am writing to address two concerns:

1. **The reduction of sessions under the Medicare Better Access scheme, from 18 to 10**

Within my private practice, I pride myself on reviewing relapse prevention methods and collect patient satisfaction data at four intervals – commencement of treatment, at a 6 week interval, at a 12 week interval, and at discharge. According to the practice data, my patients have required an average of 8 sessions for mild/slight improvements, and 16 sessions for significant improvements to be reported.

With the proposed reduction in sessions under the Better Access scheme, many of my patients would have reported slight improvements, but I believe – based on my data and evidence in the literature – that this would have left them open to relapse.

2. **The Two-Tier system under which the Medicare Better Access scheme is currently administered**

With the introduction of the AHPRA areas of endorsement in psychology, I applied for endorsement in Clinical Psychology, and was promptly advised that all that was required of me was the submission of three essays on psychopharmacology topics, and to undertake an additional 20 hours of supervision by a Clinical Psychologist to qualify for the endorsement. I do not believe these requirements warrant the magnitude of the distinction that has been made between Clinical and Counselling Psychology.

This experience further corroborates the literature, as well as the well-documented international standard, that Clinical and Counselling Psychologists share the same basic training and exposure to child and adult psychopathology training, in-patient and out-patient presentations, specialised and evidence-based interventions, and achievements in successful outcomes.

Furthermore, my professional experience has resulted in notable feedback from the GPs who refer to me, and patients who are referred to see me. Neither the GPs nor the patients have ever reported any concerns or distinctions between the treatments or outcomes I provide. In fact, the only feedback I have received from GPs and patients is glowing and gracious. Many GPs indeed have expressed confusion over what they too consider an arbitrary distinction between Clinical and Counselling Psychologists for the treatment of non-inpatient presentations (should you wish to speak with any of these GPs, I shall gladly provide the contact details, with their consent).

CONCLUSION

Based on this information and personal experience, I believe that any proposed restriction of Counselling Psychologists from the higher tier of Medicare rebates under the Better Access scheme will disadvantage people wishing to access the expertise of Counselling Psychologists, who are more than appropriately and effectively trained to meet the needs of non-inpatient presentations (primary health referrals) with mild, moderate and/or severe disorders, and equally expertly-trained to meet the needs of inpatient presentations.

Indeed, I have had a full caseload (8 patients per day) since 2003, and often have a waiting list of 3-4 weeks – a testament to my extensive training to provide specialised psychological assessment and treatment using evidence-based models for mild, moderate, and severe non-inpatient presentations.

Counselling Psychologists undertake the same level of training (six years of university training and two years supervision), as well as a remarkable overlap in the curriculum of exposure to “psychological therapies” as do Clinical Psychologists. The distinction between these two specialist areas is arbitrary and restrictive.

Lastly, based on the aforementioned, I would like to endorse the position of the Australian Psychological Society (APS) College of Counselling Psychologists: that the Psychological Therapies MBS Item be reviewed and reassessed to include all specialists of psychological practice, including Counselling Psychologists, and agree to the term “Specialist Psychological Therapies” to ensure authentic better access to mental health services to all members of the public, minimising any unnecessary and arbitrary confusion that Clinical Psychologists are in any way more trained or more effective than other specialist psychologists to provide psychological therapies to address moderate and/or severe disorders.

I welcome any opportunity to further discuss these matters with the Committee, or provide any further information, as requested.

I thank you for the opportunity to share my experiences and contribute in this small way to the inquiry.

Yours faithfully