5 August 2011

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

Dear Committee,

RE: COMMONWEALTH FUNDING AND ADMINISTRATION OF MENTAL HEALTH SERVICES

I am writing to express my serious concerns, as well as those of my patients, about the mental health funding of the Better Access Initiative. Specifically, they relate to the proposed changes to the number of treatment services available for Better Access patients; and the two-tiered Medicare rebate system for psychologists.

I have been a psychologist, with a Masters degree in Psychology, for about 18 years. I am a member of the APS College of Counselling Psychologists and an "Endorsed Specialist" Counselling Psychologist under the Australian Health Practitioners Regulation Agency (AHPRA). After graduation, I received formal supervisions from a senior clinical psychologist and a senior psychologist, both of whom were my managers at the workplace. I worked in the Community Health Centre for the first few years then later moved to the private sector and eventually established my own private practice in 2000. Like my colleagues, I undertake 30 to 100 hours of continued professional development each year. In my private practice, my referrals come from a variety of sources, including GPs, Psychiatrists, Hospitals, Mental Health Crisis Team, Government and non Government Agencies. I offer bulk billing for disadvantaged members of the community, such as the low income earners and the unemployed. In addition to English, I also speak Cantonese, Mandarin, Hokkien and Hakka, therefore a large proportion of my patients also come from non English speaking background.

The Proposed reduction in the number of treatment sessions

Contrary to what some believe, psychologists rarely cater for the so called "worried well". Most of the patients I see have moderate to severe mental health disorders such as Major Depression, Anxiety, Post Traumatic Stress, Schizophrenia and Bipolar, just to name a few. Many have dual or multiple diagnoses or complex mental health issues. Some have comorbid Personality Disorder. Some have attempted suicide, self-harmed or at risk of suicide .

Many of my esteemed colleagues have cited Australian and international research studies to support the argument that at least 20 sessions of treatment are required for common psychological disorders, such as depression and anxiety, to achieve

clinically significant outcomes. Rather than citing further research, I will illustrate my point with two recent cases from my own practice.

The first is a 36 year old unemployed woman who was referred to me, through the Better Access Scheme, by the hospital psychiatrist and the mental health crisis team psychologist and clinical psychologist along with her GP who wrote the Mental Health Care Plan. I liaised very closely with all these health practitioners. Prior to seeing me, this woman attempted suicide and was hospitalised for three months. However, a few months after discharge she was robbed in the street and relapsed. The mental health crisis team re-admitted her to hospital for a further five days. She suffered from severe Major Depressive Disorder and Generalised Anxiety Disorder. It took more than 12 sessions for her to show any signs of improvement. After 18 sessions, she was no longer suicidal and her levels of depression and anxiety have decreased from extremely severe to mild to moderate, and she has to-date avoided further hospitalization. However, upon reading the news of the funding cuts to Better Access, she became very distressed and agitated that she may not be able to get further help she so desperately needs through Medicare. She is very worried and fearful that she may end up in hospital again which is something she does not want to do. She does not speak English and has no family or any social support in Australia.

The second was a young woman who was suffering from moderate to severe Major Depressive Disorder with a comorbid Borderline Personality Disorder. She was referred to me by her GP when she attempted suicide by overdosing. On several occasions in the past she had also been cutting herself in her arms and legs with a knife. Since starting treatment, I am pleased to say, she has not harmed herself or attempted suicide. After 20 sessions (the last 2 sessions were partly funded by her unemployed mother and grandmother) she has actually found herself a job and has since returned to work. Her relationship with her mother has improved and she is planning to return home to live with her mother. She is now also planning to return to school next year to further her education and learn a skill. She still suffers from a mild level of Depression and wants to continue with treatment to prevent any relapse, which she is afraid may happen if she does not continue to get the help she needs.

I believe the proposed funding cuts reflects the government's lack of understanding of the specific and varied needs of Australians with mental health illnesses. The reduction in the number of sessions will seriously impact on the effectiveness of treatment.

Under the proposed changes, these patients will either have their services prematurely terminated or will have to move to the revamped ATAPS system. This experience can often make the recovery process more difficult for the patients. It is highly likely they will be put on a waiting list and they will also have to start all over again and re-disclose their history and presentation to a new clinician, which means another 20 or 30 sessions. Alternatively, as Minister Butler suggests, the patients can consult private psychiatrists. However, visits to psychiatrists are more expensive than visits to psychologists. Furthermore, due to a shortage of psychiatrists, there is also a long waiting list. If these services are not available or accessible, the patients will likely return to their GPs for psychological treatment or present themselves at or be taken to hospital emergency wards.

I recommend that all experienced psychologists be allowed to provide as many sessions as they assess as necessary to treat their patients, in the same manner as psychiatrists, who for the most part deliver medication, without the restricted number of sessions. Another solution is to retain the 18 Medicare funded sessions per calendar year and if further treatment is assessed as necessary by the psychologists, that they be means tested and be available only on a bulk billing basis, so that patients with the greatest needs and cannot afford payment beyond Medicare rebate will be able to continue to receive the best possible treatment

The two-tiered Medicare rebate system for psychologists

There are nine specialist areas of practice endorsement under AHPRA. It seems unfair, arbitrary and highly discriminatory, not to mention anti-competitive, that only the clinical psychologists receive higher rebate than other endorsed specialist psychologists, such as counselling psychologists. Clinical psychology is what psychologists do in a clinical setting, treating clinical problems.

Counselling psychology is one of the endorsed psychology specialties under AHPRA. Counselling psychologists are extensively trained in evidence-based psychological therapies to treat high prevalence and serious mental health disorders. I was taught psychopathology, assessments and diagnoses, for example, in my undergraduate years through to my Masters program where we shared many classes with the Clinical Masters students. APS defined counselling psychologists 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." (APS, 2011)***

There is absolutely no evidence to suggest that "clinical psychologists are treating more severe mental health population than counselling psychologists, and neither is there any evidence to support the contention that only clinical psychologists can provide psychological therapy for mental health disorders.

However, several studies (e.g. Medicare, Pirkis and colleagues, cited in Dr. Anthony Jorm's report submitted to the Committee) have found that general psychologists produce equivalent treatment outcomes to clinical psychologists.

I am not aware of any other government agencies, other than Medicare, that makes this distinction between clinical psychologists and other psychologists. For example, WorkeCover, NSW has a set standard fee for **All** psychologists of $155 per hour. Why can't Medicare do the same? From my own experience, GPs are more concerned about treatment outcomes than the artificial distinction between general psychologists and clinical psychologists.

I therefore recommend the following

1. Either increase the number of Medicare funded sessions similar to that of the psychiatrists, or retain the 18 Medicare funded session with the option for further treatment sessions if it is assessed as necessary by the psychologists and that these be means tested and be available only on a bulk billing basis, so that patients with the greatest needs and cannot afford payment beyond Medicare rebate will be able to continue to receive the best possible treatment.

2. Legislate to cease the promotion of restrictive trade practices and remove the unfair, arbitrary and highly discriminatory distinction between clinical psychologists and counselling psychologists.

3. Counselling psychologists (as well as other experienced psychologists) be eligible to provide "psychological therapy" services (items nos: 80000 to 80020) same as the clinical psychologists.

4. Set a standard Medicare rebate fee of at least $100 per hour for **All** Psychologists. Please give the public the right to have access to psychologists of their choice. Those psychologists who are competent will remain in business and those who are not will do less well.

I believe the above would give everyone equal chances and would therefore be a much fairer system than the current one.

I hope the government will take this reorganisation of mental health funding as an opportune time to redress the inequities that have been enshrined under the Better Access program.

Thank you for your consideration and the opportunity to express my concerns and particularly those of my patients.

Yours sincerely,

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c.c. Senator Fierravanti-Wells