

Committee Secretary
Senate Standing Committee on Community Affairs
P.O. Box 6100
Parliament House
Canberra ACT. 2600
Electronic Submission: <https://senate.aph.gov.au/submissions/pages/index.aspx>

28 July 2011

Dear Senate Committee,

Re: Commonwealth Funding and Administration of Mental Health Services

I refer to the Better Access initiative the Committee is about to review, and submit my perspectives from a psychologist in private practice for 18 years for consideration. These will be within three areas: 1) The proposed changes to the Better Access initiative; 2) Suggestions on cost savings within the current system; and 3) The two tiered system of payments to psychologists.

Proposed Changes to Better Access initiative

The issue of a reduction in the amount of sessions claimable under Medicare for psychological treatment.

- a) I have a concern that I will not be able to provide an effective and sustained treatment service to clients with serious medical health conditions, and or are in ongoing situations of high stress, should the Senate Committee reduce access to treatment. I am concerned that a reduction in claimable sessions has the potential to significantly damage clients that present with complex cases, by cutting their access to services before they have been adequately treated, reskilled and supported. It was my opinion that a reduction in sessions could result in a client experiencing an exacerbation of symptoms, relapse and or hospital admission. Such occurrences can then result in an higher overall expenditure per 'patient', that would be gained through the reduction in sessional funding.
- b) I have a professional concern about commencing treatment of a person knowing that there will not enough sessions to treat serious mental health conditions adequately in some circumstances. To me this raises ethical concerns, and may open areas of litigation. For clients that cannot afford access to continue treatment this can create a dilemma – to enter a treatment contract where clients are being asked to agree to start a treatment program but where where the service provider cannot deliver an effective effective treatment program because there is not enough funding to do so, in effect agreeing to not complete treatment. The psychologist is also asked to enter such a contract, again I have professional and legal concerns about this issue. To me that is not a great way to commence treatment, nor does it evoke confidence in the Better Access initiative, or the Senate Committee's changes to deliver what the Federal Government requires, nor in psychological services, but in essence serving to discredit the practitioner. I am not in a position to provide free health care, yet ethically I am obligated to provide a high standard of care by two branches of the Federal Government – 1) Medicare; and 2) Psychologists Board of Australia, and for myself there is a third that for me also requires a higher standard of accountabilities, the Australian Psychological Society, which I have been a member for over 20 years..
- c) It was my concern that a the reduction in sessions will increase work and impact upon GP's, psychiatrists, the hospital system, CentreLink and other already stretched counseling services. That this would likely increasing their workloads and create further problems for a GP in finding a place for their patient for counseling where none are available due to a lack of mental health resources.

It was my understanding the Better Access initiative for counseling was initially set up because of a lack of GP's, Psychiatrists and limited access to suitably qualified professional clinicians within the public sphere, and in order that persons who 'slip through the cracks' and or are of lower socio-economic status get access to treatment they otherwise could not afford. I can inform you that in my practice the majority of persons who are referred under the Better Access initiative are of low socio-economic background. This group are also more likely to present with more with complex and often dual or multi-mental health conditions. This group have never sought treatment prior to presentation, due to no or limited access direct access to treatment professionals. I know this information because I ask such questions at intake interviews. I wish to state many Government funded agencies that provide counseling do not employ psychologists they employ counselors, or psychologists in training. The standards, skills levels and training between counselors and psychologists are markedly different by years and the number of degree's and supplementary qualifications attained.

General Practitioners refer patients with serious health condition's that in many cases can be urgent, and for emergencies that are life threatening. I am trained to manage and treat these issues. Examples of health conditions that are referred to me by local GP's under Better Access initiative are: Post Traumatic Stress Disorder; Clinical Depression; Anxiety disorders; Persons with terminal health conditions; Serious and or chronic health conditions; Personality Disorders; Substance/s dependence; Bi-polar disorder;

Ongoing situational examples people are referred by GP's for consult are: carer and or parent's of a person, adolescent or child with - terminal illness, intellectual disability, physical disability, Asperger or autistic syndromes (including adults with condition), or chronic illness. The managements and coping of persons with aged and or aging parents with failing health has increased within my practice in recent years, as their carers or families cannot get places of them in nursing homes or palliative care because they are not deteriorated quite enough to meet the criteria, and or there are no places available; Other ongoing stressful serious conditions are areas of Domestic violence; Sexual abuse; Victim/s of crime and or violence where compensations are not forthcoming; Unemployed; Retrenched older persons unable to find employment;

I do consider it abusive to cut treatment short to persons who present for treatment at one of the worst times in their life, without the money to afford professional treatment. I cannot see how a Better Access initiative can work successfully if Senate Committee decides to no longer provide the option of extended treatments to such persons in exceptional circumstances, thus reducing treatment their treatment time by up to 8 hours.

Psychologists' are not popular persons to visit, no-one likes having to attend, they like to leave at quickly as possible unseen and unnoticed, and mostly without other persons knowing they have attended. I have been trained to view my job is to be 'sacked' as quickly as possible. I tell persons this when they first enter counseling, and that I have one of the few occupations where the goal is to be redundant (to the client), and can feel good that that is the case.

I wish to inform the Committee that the results of my work directly affect a clients ability to: remain in their university course, school or training; reduce time away from work, and time returning to work; and provides the support of many families where the parent is the sole provider yet is struggling to manage without appropriate and focused interventions. When a pivotal member of the family such as a parent or guardian develops a mental health problem it affects everyone around them, and the whole functioning of a family, as do persons with mental health conditions.

Suggestions on Savings to Current System

I had noticed within my practice, that clients who have private health insurance that includes coverage of psychological treatment, do not use, and or claim psychological treatment. That instead they are referred for treatment under the Better Access initiative, and claim their treatments under Medicare. This means that private health funds are currently financially benefiting, and profiting from the Better Access initiative, as there is no requirements for persons to access their own insurance for a rebate of treatment, when their insurance covers psychological treatment. The current structure is set up to subsidize the private health funds.

It may be, that it is not cost effective for the Government to address this issue, but to me is worth setting up a series of guidelines to ensure that persons claim for what they are insured for, perhaps before they access Medicare funding. In the least it may be beneficial to the Senate Committee to close these loopholes that benefit private health funds. It may be that the private health funds do not appropriately rebate for psychological treatment, that it may also be appropriate that they be required to fund this area appropriately, and in the least, cover 6 to 8 sessions of psychological treatment, given that research suggests that number of sessions is average people attend. Again that would be a cost savings to Better Access initiative fundings.

Noted is that the Government has no requirement of persons to select the psychological treatment option when taking out their private health insurance. Psychology is always assumed and considered an extra's option just like dental. Perhaps its time for psychological treatments to be perceived as an essential component within health insurance coverage, rather than optional. This is given that at least one time within a persons life, they will require professional assistances and support with a mental health issue.

It is my understandings GP's are not required to ask a patient if they have psychological treatment covered in their private health insurance policy. My experience is usually people don't know if their insurance covers psychology, or they inform me they always select massage and dental coverage rather than psychological treatment as an extra's option. I was informed they selection this option because they never expect themselves, or their family to have a psychological mental health issue arise.

I am also aware that some persons referred by a GP for counseling under Better Access initiative can easily afford counseling with a psychologist, yet claim under Medicare simply because the GP has referred under Better Access initiative Medicare code, rather than a straight referral. There doesn't appear to be any restrictions via income means testing, or other methodm to preclude any person from referral under Better Access initiative. I have treated persons who have annual incomes well in excess of \$100,000, some higher than \$250,000 whom could easily afford counseling. All draw upon Better Access initiative funding, simply because there are no restrictions at the point of referral, and or within the guidelines and or mechanisms in place between private health funds and Medicare or some other process.

I was my belief that consideration of the above may not only produce savings, but that may assist to fund shortfalls for those persons in exceptional circumstances who are in need to extended counseling treatment in order to be treated appropriately.

Medicare and the Two Tiered System of Payments to Psychologists

As a Counseling Psychologist I take issue with the two tiered system of payments of psychologists by Medicare. I trained for 8 years. I am a Specialist in my field not a general psychologist. I trained for the same amount of years as a Clinical Psychologist, yet my abilities and 18 years of experience have been determined as inferior to that of a Clinical Psychologist. This is even when in my training I worked in Clinical Psychologist settings, carrying out clinical psychology duties, and had clinical supervision training, as well as counseling supervision. I was also eligible for both Specialties, but in 1997 made a decision to not register with the State

of Victoria as Clinical Psychologist as ones 'specialty' was never an issue then, just like it is currently not an issue overseas. No other country in the world discriminates against psychologists like this. Counselling psychology is the second largest speciality in Australia, yet is determined inferior, and remunerated accordingly

I am required to write a reports to a GP every six sessions because apparently I am not able to assess and review my own work as to weather a person requires continued treatment, yet I am entrusted with peoples lives and all the responsibilities that entails. I am required to make assessments, provide my specialist opinion and make recommendations, to write up medical records, do administration tasks, make phone calls, sometimes discuss clients cases with their GP's, their lawyers, and or other health professionals involved, to do psychological testing, to provide emergency support, to get persons to hospital if need be, talk to parents, family members as required, do mandatory continued professional development training, acquire regular peer supervision, keep multiple records to account for these things. All these tasks are costly, they take time, where much of this time I am not remunerated. Yet, in most cases, I do exactly the same work as a Clinical Psychologist, and am paid less.

Best wishes with your discussions, this is a volatile area, where a lot of persons are anxious about the outcomes and what will happen to their treatment, and of course there are others with vested interests including Government cost savings. I don't envy your positions. Thank you for your hard work.

Yours sincerely,

Angie Paton MAPS