17th July 2011

To whom it may concern,

I am writing in response to proposed cuts to Better Access funding for mental health.

I am a clinical psychologist working in private practice in Ballarat and Melton. The client population I service are proportionally disadvantaged from a socio demographic point of view. My clinical services rely heavily on the contribution made by Medicare to cover the cost of individual counseling. Around 50% of the work I do is "bulk billed", meaning no out of pocket expense to clients. This work is provided for individuals on health care cards, namely pensioners (aged and disability support), job seekers (including long term unemployed) and carers. My fees are intentionally kept low to recognize the difficulty for majority of my clients in meeting the expense of psychological counseling.

The western suburbs and regional areas of Victoria have been under resourced with regards to mental health services for a considerable period of time. Without proper funding of public mental health services, better access provides some coverage for individuals with a diagnosable mental health condition to receive high quality, evidenced based treatment in their local area. This effectively plugs holes that are currently evident in the mental health system. Recently, significant money has been directed to other mental health services in the May budget. This money, however, is predominantly aimed at child and adolescent services. While welcome, this money does not cover all individuals who are dealing with mental health issues. Indeed, many of the adults I see with chronic mental health issues have never received effective treatments in their lifetime, due to the neglect of successive governments in providing adequate mental health funding. It would be tragic to create more ongoing difficulties for these individuals in their access of effective psychological treatment. Effectively creating a generation of disadvantaged individuals.

Reducing the number of sessions from a possible 18 (in exceptional circumstances) to 10 (in all circumstances) represents a move in the wrong direction for mental health funding. It has been recognized that the area has been underfunded and neglected for some time. Recent initiatives to increase funding into mental health are very welcome, but really represent playing "catch up" with the need in the community for mental health services. Most effective Cognitive Behavioual Therapy treatments, generally require a minimum of 12 sessions to derive the full benefit of reduction of symptoms. This will, however, ideally often extend to between 15 and 20 sessions of treatment to provide follow up and to maintain gains made by individuals. Therefore, according to best practice, current funding of 12 sessions should be maintained at least, but preferably extended. This makes the current decision a step back for mental health when the direction needs to be forward to make up for lost time.

The speculation that clinical psychologists will have their rebate reduced to a single tier of rebatable services with generalist psychologists, is of great concern to myself and the viability of my practice. During my training I was able to perform in the highest bracket of students studying to become registered psychologists and thereby was able to gain a place in the "clinical stream" of psychology. The training I received was specialized, to deal particularly with evidenced based assessment and treatment of the full range of mental health disorders. This is quantitatively and qualitatively different to the training received in other streams of psychological practice, where this focus is placed alongside other priorities for study and training (e.g., general counseling, child & family). Following, the completion of my tertiary studies, I have been required to hold myself to a higher standard of professional development to remain eligible for provision of clinical services under the Better Access scheme. This has included clinical supervision and clinical professional training. The focus of this training is specifically aimed at improving the provision of services currently rebated by the better access scheme.

There is of course an increased cost in maintaining my eligibility for the provision of clinical services that goes with the increased Medicare rebate. I would say that if the rebate were reduced for clinical services it would be very difficult (although I am inclined to do so despite the fact) to maintain my current level of bulk billing psychological services for concession card-holders or minimal gap payments. The increased cost of services through a gap payment means that individuals who need assistance will be less able and therefore have their access to psychological services reduced.

In my clinical work it is evident that individuals dealing with social disadvantage often have greater challenges in their access to health services through their lifetime. They are therefore also often less aware of the benefit of psychological counseling as it has never been experienced by themselves or those close to them. Social disadvantage is also involved in creating more complex mental health need through outside factors (e.g., homelessness, poverty, alcohol and drug addiction, domestic violence, crime). Generally, my work with individuals who have experienced significant disadvantage is that it requires more specialized skills and understanding of mental health assessment and treatment. At this stage, clinical psychologists, receive the highest level of training at tertiary and post tertiary levels and are therefore, generally the most equipped to help individuals with chronic mental health issues.

One of the most pleasing aspects of the work I do is to help individuals who have struggled for sometimes decades with mental health issues and to see them start to stabilize themselves and their lives. I hope that the senate will consider the longer-term implications of cutting funding to an already underfunded area.