

**3rd August, 2011**

**ATT: Committee Secretary  
Senate Standing Committees on Community Affairs**

**Re: The two-tiered Medicare rebate system and work force issues for psychologists.**

**Cutting of funded visits from 18, in exceptional circumstances, to 10 per calendar year.**

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Author 1: My name is Dr Jonathan Andrews. I am a Clinical Psychologist with 10 years experience in the profession. I am registered with the Psychology Board of Australia (PBA) and I am a PBA-approved Supervisor. I am a full member of the Australian Psychological Society (APS), the College of Clinical Psychologists and the Australian Association of Cognitive Behaviour Therapy (AACBT).

Author 2: My name is Dr John Warlow. I have been a practicing Adult, Child and Family Psychiatrist, since 1990. For ten years I was the Director of Training in Child and Adolescent Psychiatry for the Royal Australian & New Zealand College of Psychiatrists, Queensland.

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## **Summary**

The decision to cut the higher rebate of clinical psychologists, and cut the number of funded visits will be inimical for the mental health of the sufferer. It will leave sufferers either untreated, or undertreated making them vulnerable to relapse.

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Dear Committee Secretary,

We, the authors of this document, believe the proposed changes stated above are ill advised.

### **Needs and training – an ideal match**

In 2006 COAG released the ‘Better Access to Mental Health Care Initiative’ under the National Action Plan on Mental Health. Both the plan and the initiative were undertaken to address the massive need that exists in Australia. It meant a sufferer could more easily access assessment diagnosis and treatment for their mental health problems.

A registered Clinical Psychologist in Australia is distinct from other psychologists. Their contribution is not more valuable than the contribution made by other psychologists. Their contribution simply makes them a best fit, for the needs that we have in the assessment, diagnosis and treatment of diagnosable mental health conditions. They have been made distinct by the extent (distinct from the Generalist Psychologist) and type (distinct from other specialisations within psychology) of their training. The extent and type of their training puts them in an ideal position to meet the needs of those struggling with diagnosable mental health disorders.

The distinction between Clinical Psychology and other different but related disciplines has already been recognised in a variety of ways by many different parties. Such parties include regulatory agencies (Australian Health Practitioner Regulation Agency - AHPRA), Boards (Psychology Board of Australia - PBA), Government sectors (i.e., Medicare), organisations (i.e., Australian Psychological Society – APS) and the Commonwealth Government’s Department of Veteran Affairs (DVA).

In brief, Clinical Psychologists have been trained for the specific task of addressing the mental health challenges faced by suffering Australians, and their distinct role in addressing these problems has already been recognised.

### **The problem with the proposed cuts**

If funding is cut, then the sufferer will have to fund more of the expense.

Many sufferers of mental health conditions are unable to work full time as they are compromised by their condition. That is, they simply do not have a lot of money because they cannot sustain themselves in full-time employment.

The current higher level of rebate, allows minimal out of pocket expenses for the patient. This will not be possible if the higher rebate is lost. This means that the sufferer, already compromised in their ability to earn money, will have to fund more of the cost.

The impact will be similar if the number of funded sessions is cut from 18, in “exceptional circumstances”, to 10 per calendar year. In actual fact, 12-18 sessions of treatment is the norm in the research literature never the ‘exception’.

There is a significant portion of our community that simply requires a longer course of treatment (that is, beyond the normal amount as mentioned above) to overcome their mental health battles. They have had chronic and complex mental health conditions. This is a social reality.

Effectively, if the government decides to cut funding from 18 to 10 visits per year, it will add a financial burden that they may not be able to bear. Those very people who are too distressed to work full time, are the ones that will foot the bill for the withdrawal of government funding.

We wonder if this is compassionate.

### **Why Change something that is already working well?**

The response that often gets made is that such people (who struggle with chronic and complex conditions) will be cared for through other means (such as by psychiatrists) or other programs (public hospital team based approaches).

These suggestions are surprising. They ignore the reality that the psychiatrists are often the very ones referring these chronic and complex patients to the psychologist in the first place. Their books are often full, and the out-of-pocket expenses are often higher. Put plainly, they cannot go back, because they have just come from there! Often they do not want to go back, because it is too expensive.

The suggestions are also surprising because they imply that these chronic and complex cases, those in ‘exceptional circumstances’ that require more than 12

visits per year, are not being supported by a ‘team’ of professionals in the current program. This is untrue. It is common to have frequent and collaborative correspondence and conversation with the referring psychiatrist and General Practitioner, in which feedback and advice is sought and given. The patient is already supported by a team.

Additionally, such suggestions overlook the results of the good scheme already in place. Such patients are already being cared for and effectively treated by Clinical Psychologists as we speak. They don’t need a different sort of treatment. They need more of the same treatment. The results are in regarding the effectiveness of the Better Access program, and they are glowing. Why alter something that already works?

**The decision to cut the higher rebates, and cut the number of funded visits will be inimical for the mental health of the sufferer.**

If the proposed cuts are implemented, it will leave sufferer’s condition either untreated, or undertreated.

The Better Access program as it stands makes it possible for patients to get better access to treatment. For example, it is a common scenario for patients to be referred for treatment to a clinic by a counselor, because the patient can’t afford the expense of the counselor. The patient can afford to come to a clinical psychologist because of the rebate.

If funding is withdrawn (higher rebate, and the number of funded visits), the most likely outcome is rupture in the treatment process. This will occur in three ways.

1. The patient may either not be able to access treatment at all because they cannot support themselves financially through the treatment process.
2. If they can, they may find they can only support themselves during that time that they get a rebate (ie for the first 10 visits). In such circumstances they will most likely not get resolution to their condition in that short amount of time, they will cease their treatment prematurely and this will make them vulnerable to relapse. This will lead to a further financial burden for the government down the track.

3. Being referred to a new 'team' will lead to a discontinuity of care, with patients having to start over the treatment process with a new support structure (new clinician, different treatment approaches). They will most likely not even take up the referral, but will instead come back to the same treating clinician when the calendar year clicks over.

We do hope that you will consider alternative ways of cutting costs as the above stated suggestions will be inimical for the sufferer both financially and therapeutically.

Regards

Dr Jonathan Andrews

Dr John Warlow