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Dear Secretary of Senate Committee on Community Affairs

I am writing to express my views about the proposal to cut the number of Medicare funded mental health care sessions that a patient can claim in a year from 12 + 6 to 6+4, and the proposal to do away with the two tiered payment of psychotherapy providers. While the imperative of containing costs seems to be incredibly responsible and that seems non-negotiable, I feel strongly that these changes are likely to disadvantage those who suffer a mental illness and are consequently among the most vulnerable members of our community. When the mental illness is severe the person's ability to participate in education and maintain relationships and productive employment is usually compromised. When a person with a severe mental illness also has financial difficulties and little or no relational support network their recovery is hindered. If medication fails to relieve their condition they can not afford psychotherapy. Many such individuals end up homeless or self-medicating with illegal drugs and alcohol. A few of the lucky ones find help through the public mental health services and some qualify for a disability support pension which while a valuable support would not be adequate to pay the cost of psychological treatment if the person is also paying for accommodation.

My submission speaks to these proposals from three perspectives that of: a Nationally Registered Clinical Psychologist; a Sub-contractor of Private Clinical Psychology services; and from a consumer's perspective as the mother of a daughter who 20 yrs ago (before Medicare rebates were available) suffered from a mental illness.

1. The National Registration of Psychologists and other health professionals recognizes the speciality of Clinical Psychologist and anyone wishing to be registered and work as a Clinical Psychologist has to provide evidence of appropriate educational qualifications including the required number of hours of supervised work experience. If there was no difference between the scope and quality of work done by a Psychologist and a Clinical Psychologist then there would be no reason for the Registration Board to insist on such stringent requirements being met for register as a Clinical Psychologist. Further the Registration Board sets out more stringent requirements for the ongoing Professional Development of a Clinical Psychologist than those required for a non-specialist Psychologist. The reason these demand exist is because of the differing knowledge, approach, experience and skill levels of these two different groups of practitioners. The Clinical Psychologist has had to demonstrate a broad theoretical knowledge and competency in assessment and an ability to devise tailored interventions that can be flexibly adapted for patients across the lifespan. This is a much more comprehensive approach to treatment that that taken in the delivery of focused cognitive interventions such as behaviour modification strategies, relaxation exercises, or activity scheduling.

Even the Industrial Relations Commission endorses a difference between the work value of a Psychologist and a Clinical Psychologist in Australia assigning the latter a higher industrial Work Value. This endorsement is now embedded within Australia's Industrial

Relations Awards. This would seem highly relevant to any review of the two tiered Medicare System which takes into account Work Value.

2. As a Sub-Contractor providing psychotherapy in a private setting I feel that providing effective evidence based treatment also includes the taking a thorough history, making a focused assessment of the client's difficulties, providing psycho-education about those difficulties, tailoring treatment interventions to address the client's individual difficulties, providing ongoing support as the client integrates these interventions into their daily life and finally putting in place relapse prevention strategies. This is a tall order even within a 12 session framework. Treatment that proceeds without adequate assessment will often miss the mark no matter the evidence attesting to the techniques effectiveness. In dealing with Medicare clients over the last few years I have been surprised at how often I have received a GP referral that listed a diagnosis or focus of treatment that was quite different from that revealed by my focused assessment. This first step is vital but it takes time. Even where a person is allowed 12 sessions assessment is often briefer than best practice would allow. Some client's who are highly defended must develop a sense of trust in the clinician before they can speak about their difficulties openly. Often they have lived for many years alone with their symptoms and distress because they are ashamed. 12 hours is a short time. If treatment was limited to six sessions it would be very difficult to do an adequate history and assessment as part of treatment. Both of these aspects of the treatment help to build the rapport and understanding that then facilitate a treatment alliance strong enough to promote lasting change. Much research has shown that this relational aspect of treatment is the most salient aspect of treatment regardless of orientation of the treatment. Most clients referred to a clinical psychologist for treatment are not suffering from short-term mild to moderate symptoms that will respond quickly to treatment. Instead this client group are more likely to have longstanding complex difficulties with co-morbid disorders, as well as, substance abuse and complex or multiple trauma backgrounds. Where such a client has had previous treatment that was not effective or has trust issues the development of a working alliance may take more than six one hour sessions. Even the maximum of 18 sessions now allowed is inadequate for treatment of complex clients especially if personality disorders are also involved.

The client who experiences improvement but then relapses is often worse off than when they began treatment. For example a depressed, panic disordered client who begins to reduce the severity and frequency of their panic attacks and starts to feel more optimistic by the end of the 6 sessions, but has not integrated these changes and has not had time to be given relapse prevention strategies will be vulnerable to a relapse. If a relapse occurs after treatment has ended the client will likely become discouraged and may decide they are beyond help and will not come back for further help. Much research has shown that psychotherapy has an effect in rewiring the brain but the creation of new neural connections in the brain take time especially when the existing connections are very strong.

The idea that people who need more than six sessions will be likely to pay the full cost of further sessions is ok in theory where a client has an adequate income and support. But this is not the case for a large number of the clients I have seen in the Western Suburbs of

Melbourne. Single parents, the unemployed and the under employed and families with mortgages on average wages would all find it almost impossible to pay even the bulk bill rates for therapy. Why are the necessary savings not being met through means testing these services rather than by reducing the number of sessions? What will happen to the client who after six sessions still needs further treatment but can not afford to pay for it? Will they have to wait a year or be referred to a public mental health service? A year can be a very long time if you are severely depressed or coping without support. Having worked briefly in a public mental health setting that was having difficulty coping with the demand I feel that unless the client was in severe risk they would likely to be put on a waiting list and once they do get a place they will have to start over again repeating their stories and forming a new therapeutic alliance. Some clients with complex difficulties may have to go through this process a couple of times due to the high staff turnover in public mental health.

The work I do as a sub-contractor of psychological services is emotionally draining work but it is satisfying and meaningful work and I will no doubt keep doing it no matter what your decisions. One of the reasons for the stringent requirement for supervision and professional development is to help prevent the burnout of practitioners. Therapists need to be mindful of their own emotional health. Like me many practitioners work part time as a way of balancing their needs with their work. If I suddenly find my income reduced because a lower rate of rebate is paid I will be faced with a choice of either seeing more clients and increasing my stress or supplementing my income in some way. For me personally I have some options, but some younger therapists, who have families and mortgages, increasing their client load may not be possible or responsible.

3. Twenty years ago I had a 20 year old daughter with severe depression who was suicidal for three years. We had a low family income and five children. As soon as we became aware of her difficulties we tried to get her some treatment. But finding treatment for her was a struggle. She went on a public hospital outpatient waiting list, nothing happened for months. She saw a counselling social worker for a few weeks who she liked but this worker then left the service and when she was replaced with someone new my daughter stopped attending. Finally my daughter was seen by the hospital psych team as an outpatient. Shortly after that it was apparent she needed hospitalization but there were no public beds available. This was a terrible frightening time for all of us. Without our private health cover she would not have survived. Recovery took time she did not respond to the different medications she was given. She needed ongoing psychotherapy. But we could not afford it. The psychotherapy she needed only finally became possible when she was granted a disability support pension and living at home allowed her to afford to pay for the two years of weekly therapy sessions her recovery took. In the process she lost her independence having to return home and so it took a long time for her to regain her confidence. She needed way more than 10 sessions. I am sharing this because I know how desperate someone can feel if they need help and can not afford it. Please consider this when you make your decisions. Today my daughter is a fantastic asset to our community and gives back to the Australian health care system in her work everyday. Many people are not so lucky. They don't have the resources we had and they fall through the cracks. When the Medicare Mental Health Care Scheme was introduced

it not only responded to a great need in our community it said, loud and clearly to everyone, that people needing psychological treatment were worth it and that they no longer needed to be ashamed to seek help. I firmly believe that this is an intervention that needs expanding not contracting and that to reduce it will cost us much more in the long term than providing adequate treatment, because mental illness left untreated impacts a huge number of people and is often passed on to the children of the next generation. Please do not make this just about economics.