

Louise Trimble
Clinical Psychologist
Berwick Counselling & Psychology

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

19th July 2011

To Whom It May Concern

Re: Senate Review Committee decision regarding Medicare tiered subsidies for Clinical Psychology services

What is the cost to society of a life lost? – over \$2,000,000.

I completed a Master of Psychology Degree (Counselling) at Monash University, six years of full-time study, and became a registered psychologist eleven years ago. I work in a Private Practice in the Southeast region of Victoria.

When the Medicare scheme for psychological services was introduced, I was extremely disappointed with the two-tiered structure, which I believed was unfair.

In order for my clients to obtain a higher rebate I decided to complete further studies, and supervision, to become a “Clinical Psychologist”. This was undertaken over a two-year period, costing me several thousands of dollars.

I now believe however, that I am a much better psychologist providing a higher calibre of expertise because of my further training in Psychopathology, Psychotherapy, Psychopharmacology, and Clinical Supervision. I am now proud to call myself a “Clinical Psychologist”. I feel that I am better able to meet the demands of more acute psychopathology that I am now presented with in a private setting (rather than the “worried well” which I was dealing with previously as a generalist psychology)

As part of my requirement for my Masters in Psychology at Monash University in 1999 I conducted research among clinical and counselling psychologists (members of the Australian Psychological Society). The results of that study clearly showed differences with the level of acute cases of psychopathology, and therefore with client suicidal behaviour, between clinical and counselling psychologists. Clinical psychologists were more likely to be treating high risk clients.

There were also significant differences between the interventions implemented, and their rating of effectiveness, between clinical and counselling psychologists. The reader can refer to my published journal article in the *Australian Psychologist* Vol: 35, No: 3, November 2000; or read my 40,000-word thesis at Monash University. (The thesis is recommended reading for all current Master of Psychology students at the university.)

Some of the clients referred to me by general practitioners, now that I am a clinical psychologist, are presenting with more acute psychopathology and therefore are higher risk clients than those previously seen when I was a generalist psychologist. Care of a patient is of great importance to me and I acknowledge that every preventable death is a saving to the community, the health system, and to the country, and has far-reaching ramifications. It is not only the loss of the person (as in a suicide) but their death can affect that persons' family, friends and the next generation of family members.

As a clinical psychologist, I conduct psychological assessments regularly with my clients. I measure their level of depression, anxiety and stress at intake, and after each six sessions in therapy. I have been very pleased with the results achieved and feel that the work I do is invaluable for their recovery. I also perform "clinical" assessments thanks to my advanced studies and training to become a "clinical psychologist". I can then provide and treat my clients with a higher level of expertise. I therefore believe in the need to maintain the status quo and have a two-tiered Medicare system.

From my own recent experience, I had a suicidal client in my rooms last month. I believe that as a "clinical psychologist" I was better trained, and able to manage the situation, than had I not upgraded my credentials from that of a generalist psychologist. Not only was I able to liaise with the woman's General Practitioner, psychiatric triage, CAT team, and hospital staff, but I was able to get her to safety and keep her alive in a very serious situation. The threat of her suicide involved not only the lady in question, but also the potential of her husband being killed or injured in the process, and her two children witnessing the tragedy.

A study undertaken and published in December 2005 by the Ministry of Health in New Zealand titled "The Cost of Suicide to Society" had an estimated total cost to society for each suicide of \$2,931,250. The report breaks down the total into economic and non-economic costs (see <http://www.moh.govt.nz/moh.nsf/pagesmh/3347>).

As a clinical psychologist in just this one example, according to the New Zealand study, I have saved the country many hundreds of thousands of dollars that would have been lost in economic production, at a cost of millions of dollars to society, let alone the social impact of the woman's suicide had she been successful.

This is an example of why the two-tiered system must survive. This also supports the argument that 10 to 12 sessions of psychological counselling is insufficient to provide a level of care to some clients, and that "exceptional circumstances" should be maintained. As a clinical psychologist in a busy private practice I try to minimise the number of sessions with clients. I certainly do not

encourage malingering. Some clients presenting with more serious mental health issues however, do require at least 18 or more sessions per annum and so I quite regularly provide my services pro-bono to several clients each year.

More universities need to offer clinical masters' programs to students because we have a shortage of "clinical psychologists". I believe this is possible, and should be supported by the Australian government. We need to be encouraging students into the clinical masters' program, which provides them with better knowledge and skills to save lives, which will not happen if the rebate is reduced to the base level.

The government should not be looking at cutting millions of dollars per annum on Medicare rebates, but on saving lives, as well as spending more money to provide early intervention so that the mental health care services are not overburdened by preventable cases of mental illness. Early intervention will save the mental health care services millions of dollars because it is more beneficial to treat the patient before their symptoms and psychopathology escalate and become more difficult to treat.

Saving money in the short-term which ultimately will cost the government more in the long-term, is a false "short-term" costing solution. We need to look toward saving lives, rather than saving dollars in Medicare rebates.

When you look at the previous mentioned New Zealand report, and the cost to society of suicides and attempted suicides, psychologists' costs are a very small part of the total cost. It can be argued that rebates should be increased, and the number of sessions also increased for "exceptional circumstances" to ensure there are adequate numbers of psychologists available for preventative care.

There is insufficient data to make arguments to reduce the rebate for clinical psychologists, or the number of sessions provided. An \$80 rebate for clinical psychologists is not viable, but would be a disincentive to become a clinical psychologist. This therefore would lead to a cost to the community, increased suicides, more pressure on the CAT teams, hospitals, families of people with mental health problems, and loss of productivity. The program is running successfully with the two-tiered system and up to eighteen sessions per annum, so why dismantle it? The existing program works well now, so we should be asking what we could do to improve it, certainly not to change it.

In summary, if the lives of a few tens of people are saved in a year as a result of a well-trained clinical psychologist then any perceived additional cost to the health benefit system of clinical psychologists getting a higher rebate for high risk clients is negated. In fact I believe if the current system is changed, the overall result is highly likely to be an additional cost to the country.

Yours sincerely,

Louise Trimble
Clinical Psychologist