10th July 2011

Re: Proposed changes to Mental Health funding

Dear Committee Members,

I am writing to express my concern regarding a recent suggestion by the Senate Committee to change the proposed two-tier system of Medicare funding for clinical and generalist psychologists.

I am a privately practicing psychologist with a clinical speciialisation. My initial training as a secondary school teacher led onto further post-graduate training as a psychologist. After several years of study I qualified as a psychologist with a Master of Psychology (Counselling). After this I worked in a number of areas before eventually heading into private practice. Fortunately I developed a good reputation and received referrals to treat a number of conditions- however it was apparent to me that I needed to further my study in order to provide my patients with the best possible treatment. I decided to engage in another 18 months of study (on top of the seven years full time study already completed), so that I was able to complete a clinical specialization. This level of study has had a marked impact upon my service provision. Psychopharmacology, psychopathology, consideration to individual case studies, use of empirically valid treatments including cognitive behaviour therapy were all the focus of study during this time- these topics are all imperative to being able to practice as an independent psychologist diagnosing and treating a wide range of psychiatric conditions, including anxiety disorders (obsessive compulsive disorder, panic disorder, post traumatic stress disorder), mood disorders (major depressive disorders, bi-polar disorders) and schizophrenia and other psychotic disorders, yet this training was not provided in any of my previous study. I am greatly concerned that consideration is being given to removing the delineation between clinical psychologists and others, and can report that having training in both 'areas' of psychology, that it is *clinical* psychologists who are best equipped to deal with complex psychiatric presentations often referred in private practice.

I am concerned about a recent 'study' conducted by a small group of psychologists in which 'data' was presented suggesting that there is no difference in outcomes for currently practicing 'generalist' and 'clinical' psychologists. I would suggest that the committee consider the following:

- The study did not meet fundamental standards of research design
    - It did not identify the nature, diagnosis or complexity of the clients seen by psychologists by type of psychologist
    - It did not identify the nature or type of psychological intervention actually provided
    - It did not factor in or out medication use by the client
    - It did not factor in or out therapy adherence indicators
    - It did not have a valid criterion measure actually related to a range of diagnoses or complexity in order to assess pre and post intervention condition of clients
    - It did not undertake follow-up assessment of clients, which is often the point at which the relative strength of any competent treatment becomes manifest
    - It did not determine relapse rates by type of psychologist;
    - It was a self-selected sample of psychologists who self-selected their clients and clinically administered the research questions in session; it was not subjected to peer review)

- What is needed is a well-designed prospective study aimed clearly at answering specific questions in accordance with principles of psychological research.

Patients who are referred to me often have *significant* mental health diagnoses- schizophrenia, *severe* obsessive compulsive disorder, bi-polar disorder, somatoform disorder, post-natal depressive disorders- given the nature of my training in the clinical field it is my belief from discussions with colleagues that the patients I am referred are sometimes more 'psychologically unwell' than referrals to counselling, educational, organizational, health (generalist) psychologists. These patients are often unable to work and are not able to pay a large fee for service, however this is exactly what would happen if the clinical rebate were dropped to that of the generalist. I would not be able to afford to bulk bill these patients, they would be charged a significant out-of-pocket gap fee which they would not be able to pay, and they would, as a result, cease treatment. It is my belief that this would ultimately result in a potential increase in burden on the health system, as the need to find hospital beds to accommodate these clients would increase as they became more unwell. I ask that the committee undertake serious consideration into these issues before making the decision to reduce the available rebate, as to do so will result in significant added burden to the health system.

I am also writing to express my greatest concern about the budget decision to reduce *access* to clinical psychological services under the Better Access to Mental Health Scheme. The decision to reduce access to treatment to 10 sessions per year from the current 12 sessions (with a possibility of 18 in total for the year) is greatly concerning- for some of my patients this will have dire consequences and I fear for their ability to cope and continue on their pathway to management and recovery from various conditions. As it is, for some of my patients it has not been possible to contain treatment to the available 18 sessions per year, and at times I have continued to see these patients beyond 18 sessions at no charge or a token fee (with no Medicare funding this means I am effectively working in a voluntary capacity). In reality these patients often require up to 30 sessions in a year in order to maintain gains in mental health they are making during treatment. An example of this is in the case of clients with severe obsessive compulsive disorder- the prescribed treatment for this condition- exposure therapy with response prevention, a type of cogntiivie behaviour therapy which is considered worlds-best practice in the treatment of this condition, requires structured sessions in which the client Is engaged in weekly exposure therapy with response prevention exercises to reduce their obsessive compulsive behaviour. Treatment manuals outlining this therapy refer to 21 plus sessions of treatment, which is considered an appropriate approach in managing such a condition (refer March, J.S. & Mulle, K., OCD in Children and Adolescents, 1998, Guilford Press: NY). To commence treatment with such individuals knowing that therapy can not be continued beyond a certain point is very concerning, and may even be considered psychologically detrimental. The decision to reduce the sessions to almost half means that treatment will cease and outcomes will be devastating. These patients will not be able to afford treatment without Medicare assistance and I would ask that you advocate these concerns to Parliament. It has also been my experience that access to psychiatrists is limited and I do not imagine that the psychiatric profession will be able to 'take up the slack' caused by the ill-thought through decision to cut Medicare funding for Clinical Psychological treatment.

Yours Sincerely,

Julie Brown
Psychologist (Clinical specialization)