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Psychologist

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

Dear Committee

RE: Commonwealth Funding and Administration of Mental Health Services.

I am a Counselling Psychologist working in Private Practice in an outer suburban area of Melbourne. I have been a registered psychologist since 1984 and have run my own Private Practice since 1991. I have specialist registration as a Counselling Psychologist and I am a member of the Australian Psychological Society College of Counselling Psychologists. I am writing this submission as my response to the proposed changes to the Better Access initiative and to object to the two tiered structure of the current and future program.

1. **Proposed restriction of sessions**

I am concerned about the proposed changes to the number of sessions allocated to clients under the Better Access program which will reduce the access of clients from 12 sessions to 10. I work in an area where there are significant numbers of socially disadvantaged patients with often multiple psychological problems frequently compounded by co-morbid medical and social problems. It has been my experience that patients presenting with mild mental illness benefit from between 6 to 10 sessions but those with more severe presentations or multiple problems frequently require the full 12 and, at times, the extra 6 sessions under exceptional circumstances. Many of my referrals come from doctors and Psychiatrists who I have worked with for many years in a collaborative framework (before and since the Medicare initiative) and who value my experience and expertise in dealing with patients with complex presentations. My training, ongoing professional development and long experience working with patients with significant mental health issues, social and cultural issues plus chronic illnesses allows doctors to refer patients confident that I will be able to help the majority of patients or help the referrer manage these difficult patients in the number of sessions available.

Whilst receiving treatment with me patients are not being admitted to hospitals or attending psychiatric appointments as regularly as they might, therefore achieving significant cost benefits. It is not uncommon for some patients to reduce their medication intake following successful psychological treatment leading to further cost savings to them and the public purse. Given the socio-economic area in which I practice most patients are either bulk billed or pay a small gap payment which is again a cost saving to the patient and allows greater access to services to those in the most severe need.

My fear is that the reduction in number of sessions will reduce the availability of sessions for the neediest patients with the most complex problems. I am also concerned that reducing the number of sessions will impact upon the "safety net" available for patients who respond more quickly to treatment such that the last few sessions of treatment are able to be spread over an increasing time frame to foster self management and prevent relapse. In my experience the last 2 to 4 sessions of the 12 or 18 available have been crucial to allow this lengthening of contact and strengthening of patients' confidence in utilising the psychological approach in the longer term. Therefore I urge the Inquiry to maintain the status quo.

2. **Two tiered rebates system**

Since the inception of the Better Access initiative I have been concerned about the two-tiered rebate system for psychologists, both because of the inherent unfairness and discriminatory nature of this system but also because I cannot see as many clients under bulk billing as I would like to. If I was to treat only bulk billed Medicare

clients I would not be able to make a proper living for someone with 6 years University training, 2 years of supervised work and nearly 30 years working in the psychological field.

I also find it somewhat demeaning to be considered “less able” than an almost new graduate because of the name of the particular university course they have had access to, especially as counselling psychologists are extensively trained in diagnosing and treating mental disorders with evidence based psychological therapies. Given my many years of experience as a therapist I find myself in an ethical dilemma when I am told by this system that I am only funded to provide “focused psychological strategies” given that I can and do, provide so much more in treatment.

The repeat referrals I receive from doctors are based on the service I provide, the results achieved (often with patients who have not remained in treatment with other professionals) and the feedback they receive about my treatment. The perennial referrers to my Practice do not care what my particular psychological specialty is called because they understand that I work as an ethical and well trained Clinician in my interactions with the patients they entrust me with. If I wasn’t providing appropriate treatment and getting results my business would not have thrived for 20 years because I would not have been able to build up the trust necessary in my referrers

The distinction between Clinical and Counselling psychologists is arbitrary, not based on evidence and fails to take into consideration the reality of the training and expertise in the workforce and therefore should be abolished. It also penalises those patients who Counselling psychologists can’t afford to bulk bill and restricts the access that the scheme was originally designed to promote. I urge the Inquiry to redress this imbalance.

Yours sincerely

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