Committee Secretary
Senate Standing Committees on Community Affairs
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Parliament House
Canberra ACT 2600
Australia

DR Tania Pietrzak

Subject: Cuts to Medicare funding for mental health

My name is Dr Tania Pietrzak and I am a full member of the APS and a clinical psychologist in private practice and have provided treatment to my clients under the Better Access Mental Health care initiative. I have serviced approximately 600 clients in the past 3-4 years in the electorate of Goldstein Melbourne. Approximately 10% of my clients have utilised 18 sessions in a calendar year and have presented with complex and severely debilitating multiple diagnoses such as trauma, agoraphobia, and psychosis with comorbid personality disorders. Most of my clients are women aged between 30-50 years with moderate to severe depression and anxiety and approximately 70% of those have attended up to 12 treatment sessions. Cognitive behaviour therapy is a first line treatment intervention and research has shown it to be just as efficacious as medication for mental health disorders in the short term and more efficacious than medication in the long term due to adverse side effects of medication, tolerance and addiction.

Over the past 3 years pre and post measures of depression stress and anxiety following cognitive behaviour therapy treatment have shown that in my client group approximately 70% have improved to normal or mildly elevated levels of anxiety or depression.

There is a strong need in my opinion to retain the 2 tier system between clinical and generalist psychologists as clinicalpsychologists have superior and expertise training in conducting diagnostic formulations which more accurately predict a well informed and individualised treatment plan. This is crucial in working with clients with complex treatment needs that will be in my opinion severely disadvantaged by the proposed cuts to the number of rebate able Medicare psychology sessions from 18 to 10. Furthermore a good part of my clinical work is with new parents suffering from post natal depression. One third to one half of children whose mothers and fathers are depressed also go on to exhibit childhood depression- a major risk factor for suicide.

Over the past 5 years of the BOIMCH initiative evaluations of the scheme have shown good outcomes for clients in a timely, accessible and cost effective manner. The claims by generalist psychologists quoting one study of the evaluation of the scheme that client outcomes did not differ between those

treated by generalist and clinical psychologists is flawed as the study was not scientific as it lacked evidence of efficacy. It was not a randomised control design, clients and psychologists were self selected and there was no differentiation of pre-treatment client severity which would seriously impact prognosis and responsiveness to treatment interventions. More complex clients are more difficult to treat and those clients tend to be treated by clinical psychologists who have expert training in handling such populations.

The cost to public health for clients residing in psychiatric units in our major public hospitals is exorbitant and these clients under the public health care system with complex treatments needs relapse commonly and historically once discharged back in the community have not been well serviced with a poor continuity of care under the public health care model.

I am aware that there is evolving in the APS and in the psychology community a split between clinical and generalist psychologists. This saddens me greatly as I believe all members who undergo specialist training to receive eligibility to their chosen college within the APS should be given specialist endorsement by Medicare to be seen as expert treating practitioners in their area with appropriate remuneration in that chosen field. An athlete would be best going to a sports psychologist, a client with irritable bowel or diabetes would be best treated by a health psychologist and a distressed couple best treated by a counselling psychologist. A tiered system reflecting higher remuneration from Medicare for psychologists with this specialist training is one form of recognition of their additional qualifications. How far do we go in saying all allied health care providers are equal? Should a 1 year TAFE course in counselling be adequate for a person to treat a client with clinical chronic, pervasive and often life threatening mental illness? I think even the generalist psychologists would agree that the PD requirements to retain specialist knowledge as part of a specialist college within psychology once acquired protects member of the public who access our service from incompetence, and malpractice. Generalists have 30 hours of PD per year, whereas clinical psychologists have 60 hours with 30 in the clinical area. It is simply an insult and illogical to suggest that all psychologists are equal in their ability to treat complex patients as they do not receive equal training or have equal PD requirements, so why must they receive equal remuneration from Medicare items to treat complex cases such as these? Clinical psychologists receive additional training in child and adult assessment, diagnosis, formulations and how these specifically relate to individualised treatment planning. They have a good knowledge of psychopharmacology and the medical management of patients.

Please continue to fund the 18 sessions per calendar year and allow the 2 tier psychology system to remain.

Yours sincerely

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Clinical Psychologist

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