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

2/8/2011

Dear Committee

Re: Commonwealth funding and Administration of mental health services

I am a counselling psychologist who provides a range of accessible and culturally diverse psychological service, offering services to a range of CALD and mainstream group in the Eastern, South Eastern, limited Western and inner city regions. I have evolved this service from what I describe to be the least basic cost in the most practical and creative way. At the beginning I outreached my services to base myself at medical clinics, encountered some difficult practical problems that I believe at the time had an impact on quality of comfort and space for my clients. Since then I have evolved this service into a culturally relevant, diverse service accessible to a unique ethno specific service that target Chinese clients because of my bilingual skills. In fact I had provided a diverse service to CALD population before year 2000. Since the Medicare initiatives I have been limited to access the diverse CALD group, I believe I have diverse skills and experience and this became restricted because of the fact that psychologist cannot access the interpreter item.

From evidence based level I was providing a service that targets one to one counselling to group work, in the first seven years offered a bulk billing service and then gradually provide the Medicare services to include a small gap fee of $10 for low income and $20 for income earners. My experience at the time the fees ended being waive due to a number of factors. Like many of my colleagues both counselling, community and clinical psychologists in particular counselling psychologists have diverse skills and they are in fact practitioners with skills in the provision of psychological therapy for individuals. I speak for myself I have not only bilingual skills in a number of dialects and languages I in fact is disadvantaged by the way I have been exposed with not much choice to offer a range of services to individuals, couples, families and groups. I also treat a wide range of psychological problems and mental health disorders. I have also used varied therapeutic approaches and apply these to varied culturally relevant clients.

As a counselling psychologist I am concerned regarding the impact of changes to the number of allied mental health treatment services from 18 sessions to 10 sessions. From my own statistics records only a small percentage of clients need less than six sessions. For these clients I observe that the assessment from the referral is not appropriate and hence the reason why the clients dropped out is because of this problem. I think it is also a positive thing that there are clients who need less than six sessions. My experience of most clients referred also have multiple complex issues where clients need both counselling and clinical skills. As I am from a bilingual background I have psychiatric nursing qualifications, fifteen years of social work experience as well as cross cultural family therapy skills. At the grass root level I have in fact conduct cases and juggling it in the most cost effective way considering I have implemented my counselling casework in flexible and

adaptable way under difficult circumstances. My rate of fee is the 80110 item providing the skills addressing assessment, counselling, clinical including health counselling for most of the community groups I have been working with and sometimes I have to write notes after hours.
My counselling psychologist colleagues would agree that counselling psychologists are extensively trained to provide assessment, diagnosis, and evidence-based psychological therapies for mental health disorders. Since Medicare is endorsed for this profession I have actively paid for costly professional development training to gain both clinical and counselling skills. I participate in a number of Mental Health Professional Networks from different areas hoping to gain contact in a multidisciplinary way with other professions, to update my skills so that I am working effectively for my client group. I have been experiencing the disadvantage being bilingual, multiskilled and as counselling psychologist be divided between clinical and counselling psychologists when in fact I offer a range of expertise using both clinical, counselling, community, social and health counselling. In fact the unique expertise I also provide to clients include cultural competence skills. In the last three to four years I have often thought about outreaching other regions in the western suburbs (a few clients have travelled to me from Point Cook, Geelong, St Albans, Caroline Springs) and these clients have limited access to bilingual psychologists. I did not undertake this plan because of issues described in this letter also due to the restrictive limit on the services imposed on counselling psychologists. I believe reducing the number of sessions may have a significant negative impact for CALD clients. Hence I believe that counselling psychology group advocating ‘specialist psychological therapies’ item be recalibrated is a fair initiative.

I believe that a more equitable and less discriminatory arrangement under Medicare and future funding arrangements acknowledge the skills and culturally relevant competence for both clinical, counselling psychologists will result in a more accessible and relevant mental health service for all Australians.

(...)

Yours Sincerely

Khai Wong
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