31st July 2011

Senate Community Affairs Reference Committee Inquiry Into Commonwealth Funding and Administration of Mental Health Services.

To The Senate Committee investigating:

1. **Changes to the Better Access Initiative**
2. **The two-tiered Medicare Rebate System for Psychologists**

Firstly, I would like to congratulate the Federal Government for making psychological services more readily available to the general public through the Better Access to Mental Health Care Initiative, established in 2006. This initiative provided the Australian community, who previously were unable to access psychological services, due to financial constraints, a treatment alternative to "medication-only" or "no-treatment at all." It opened-up the psychological door of treatment options, to a whole section of the community with mental health disorders who had previously been excluded from such user-friendly, evidence-based treatment approaches, due to financial restrictions. **Unfortunately, I believe that it is this section of the community, who have so positively benefited from this initiative, who will be most significantly and negatively affected by the proposed changes to the "Better Access Initiative."**

As a Clinical psychologist, who works in both Private Practice, as well for a State Government organisation, I am writing to express my objection about the Government's proposed changes to the *Better Access to Mental Health Care Initiative* (*'Better Access Initiative'*) as announced in the 2011 Federal Budget.

1. Changes to the Better Access Initiative

Specifically, I am extremely concerned by the proposal that from 1 November, 2011, the yearly maximum allowance of sessions of psychological treatment available to people with a recognised mental health disorder will be reduced from 18 to **10** sessions.

Whilst new investments in mental health care are important and are to be applauded, they should not be at the detriment of existing mental health programs. For example, I understand that the Government has proposed to redirect funding from the *'Better Access Initiative'* to team-based community care (ATAPS). Personally, I do not believe individuals should be mandated to participate in treatment involving multiple disciplines (i.e., psychiatry registrar, social worker, occupational therapist, mental health nurse) in order to access psychological treatment. Under the existing *'Better Access Initiative'* many individuals have been able to access and achieve effective gains from psychological treatment without the utilisation of team-based care. On the other hand, some individuals have been redirected from multidisciplinary, community-based services for more specific intervention with individual private psychologists, under the Better Access Initiative. Removing this opportunity will remove a very effective treatment option currently available to the community, as well as removing a very user-friendly referral option for many community agencies, placing more demand on already strained, under-resourced or under-qualified, public or community-based services.

I am deeply concerned as to how much individual treatment gains will be adversely impacted if the funding for the *'Better Access Initiative'* is reduced from a maximum of 18 sessions to 10 sessions per annum. This proposal implies that the same treatment outcomes can be achieved with half the amount of sessions. The proposed cuts to the *'Better Access Initiative'* reflects the Federal Government's lack of understanding of the specific and varied needs of Australians with mental health disorders.

Clinical, evidence-based research for less complex mental health disorders, indicate an average of 10-12 treatment sessions, and in many instances this may be an adequate number of treatment sessions. However, for more complex, co-morbid presentations, it is highly ***unlikely*** that a clinician could provide effective psychological treatment in 10 sessions or less. If the number of sessions, is reduced from 12 – 18 per calendar year, to a maximum of 10 – the effectiveness of clinical treatment will be compromised and patients will receive inadequate, non-evidence-based, "express" therapy.

I believe that reducing the total number of session available to individuals with mental health disorders will create both practical and ethical treatment dilemmas. Commencing a treatment regime that can not be completed could be more harmful than helpful, and attempting to "short-cut" evidence-based treatment approaches will result in less effective interventions and goes against psychologists' code of ethics. This will result in poor outcomes associated with psychological intervention and as a consequence may result in psychological intervention being assessed by clients and referrers as being an inappropriate and ineffective treatment option.

Implications for Private Practice
Although I do not believe that the proposed changes associated with reducing the number of psychology treatment sessions per calendar year will have a negative impact on the number of referrals to psychologists. Referrals will continue to be received from GPs, Psychiatrists, etc and psychologists' appointments will continue to be filled. **However, it is the quality of the treatment that will be available to the client that will be affected.**

- I estimate that 85% of my clients would receive 12 sessions in their first 12 months of treatment.

These patients would have to be seen less frequently, or wait until the next calendar year to continue with treatment, which would put them at risk of relapse.

- 10% of my clients would require 6 or less sessions following initial referral.
- 5% of my clients would receive the maximum of 18 Medicare funded sessions.

- **80% of my clients are also bulk-billed and would not have the finances to pay for additional treatment sessions, should the total number of sessions approved under the Medicare Better Access Initiative be reduced.**

As the numbers of clients who receive 12 or more psychology sessions per calendar year has been shown to be quite low, it does not make sense to remove this service from those who no doubt have the most complex presentations and require the most intensive treatment. I applaud the fact that the recent figures showing the average number of sessions accessed by clients under the better Access Initiative indicate that the system has not been over-utilised or abused by the professionals who are providing these services.

2. The two-tiered Medicare Rebate System for Psychologists

As a Clinical Psychologist, currently working in Private Practice, as well as for a State Government organisation, I am also very concerned about the ongoing debate between Psychologists and now being raised as part of proposed changes to the "Two-Tiered Medicare Rebate System." This debate seems to be an argument regarding the Medicare rebates made available to psychologists under the Better Access Initiative, based on clinical skills, experience and expertise.

I am not going to provide details outlining the training differences between generalist psychologists and clinical psychologists, as I believe this has been reiterated in many submissions to date and that this information is also readily available from any public health and university brochures on the psychology profession.

Rather I will comment from my own personal perspective. I was initially employed as a fully registered Psychologist in a full-time psychology position in 1998, after completion of my 4-year undergraduate degree. After working for 18 months, I came to realise that I had very limited understanding of the complexities of psychopathology, and complex co-morbid presentations. Although I was receiving psychological supervision from a Senior Psychologist with "20 years of experience", who had received even less tertiary education than myself (3-year degree), I did not believe that his experience and supervision was adequately meeting my professional and clinical needs. Of my supervisor, another psychology colleague questioned if "he had actually had 20-years of clinical experience, or one year's experience, 20 times over?" Upon reflecting this question, I realised that his experience was limited by his tertiary training and the psychology work that he had been doing since his graduation. (primarily in the same government organisation for 20-years). I realised that if I was to further my knowledge of my chosen profession that I would need to return to postgraduate studies at university. I went to university with the intentions initially of enrolling in a Masters in Psychology Research Program, but was convinced that I really needed to enrol in a Masters Degree in Clinical Psychology. I did not really know what this degree entailed, but was excited by the extensive coursework component, complimented by the research work I would have undertaken had I only done a research degree.

As I was the sole income earner in my family, undertaking this degree was an enormous financial commitment, as not only did I have to pay the cost of upfront university fees, as well as the general costs associated with any university course, but I also had reduce my work status from full-time to part-time. With a mortgage and young family to provide for this was a great financial sacrifice, and at times during my 4 years of part-time study, I often wished that I had just stayed in full-time employment. **However, the clinical knowledge, skills and confidence I obtained from this course was invaluable and knowing now what the course actually offers psychologists as far as their clinical training and professional and personal development is concerned, I would never have questioned the benefit of undertaking this degree or questioned the financial sacrifice required.**

I find it interesting, that psychologists, who have not undertaken postgraduate training in psychology, believe that they can surmise on what they are or are not missing out on. **How can someone make a judgement on something they have not experienced? How can one assume that this training does not offer anything above and beyond the training that one has received having only completed a four-year degree?**

As well, I find it interesting, that although 4-year trained psychologists are making the argument that there should be no differentiation between undergraduate and postgraduate-trained psychologists, every year the universities are receiving more applications for postgraduate psychology courses than they can accommodate. Surely, if postgraduate training in psychology does not provide any additional skills, knowledge, expertise, then why are hundreds of candidates paying tens of thousands of dollars every year to pursue this training?

From my own experience, I did not know anything about postgraduate training in Clinical Psychology until I had actually commenced and completed it, so I can only assume, this would be the case for other individuals who have not undertaken this training.

Although, I do not believe that changes made by the Commonwealth will stop me working in my private capacity as a Clinical Psychologist, **I am concerned of the impact these changes will have on the patients I treat.**

I am unclear what the proposal is regarding the abolishment of the two-tiered Medicare system. I am assuming, this will mean that Clinical Psychologists will receive the same Medicare rebate as Generalist Psychologists.

My concern regarding the practicalities of this from a business perspective is that as a Clinical Psychologist currently receiving the $119.80 Medicare Rebate, I am financially able to "bulk-bill" individuals who have a health care card, up to 12 psychology sessions per calendar year. This has provided Clinical Psychology services to those in the community who are most disadvantaged and often most in need of psychological intervention.

- **80% of my clients are bulk-billed.**
- **Should the Medicare rebate be reduced, I will no longer be able to offer to bulk-bill those disadvantaged members of the community,** who will either have to find the money to pay the gap fee, or will no longer be able to access services, which to my understanding was initially put in place so that these individuals would be able to access appropriate treatment services.

The major problem for many financially disadvantaged clients is not that they can't afford a small gap fee, but they often are unable to pay the fee for services, up-front (which is currently required) and then receive the Medicare rebate. Many clients are prepared to pay $20.00 - $30.00 out-of-pocket, but are just financially unable to pay $120.00 - $180.00 up-front, per session. **(Remembering that the APS recommended fee for psychological services between 45-60 minutes for 2011 financial year is $218.00).** A solution to this problem would be to allow clients to only pay the gap fee, and the clinician, rather than the client could lodge a claim for the Medicare rebate.

I hope that the concerns raised regarding the proposed changes to the Better Access Initiative generate further consideration and that the community is not disadvantaged unfairly due to a lack of understanding regarding the intricacies of the psychology profession: how we offer treatment and the specialised treatment Clinical Psychologists offer.

Yours Sincerely
Name Withheld
Clinical Psychologists, MAPS