BA (Psych); Grad Dip Appl Psych; MA (Couple and Family Therapy); MAPS
Individual, Couple & Family Therapy

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

August 12th 2011

Re: Commonwealth Funding and Administration of Mental Health Services

Dear Committee,

I welcome the opportunity presented by this Senate Inquiry to examine funding arrangements for mental health and, as a practising psychologist, wish to comment on a number of points.

I am a Counselling Psychologist in private practice in Sydney. I have held full registration to practise psychology since 1998, and have worked in the Northern Territory, Sydney and the United Kingdom in a variety of roles. I am endorsed by AHPRA to practise as a Counselling Psychologist, and am a member of the APS College of Counselling Psychologists.

(a) The government's 2011-12 Budget changes relating to mental health

Increased funding for mental health in the recent Budget is very welcome news, however the decision to direct funds toward severe mental disorder whilst reducing the successful and well-utilised Better Access initiative is disappointing.

It appears that much of the new funding announced in the Budget is for people with severe mental disorders (e.g. psychosis, suicidality). Such clients make up a very small proportion of the population, in contrast to mild and moderate disorders which are prevalent. It is well-known that treatment for severe mental disorder is costly, and that it is very difficult for such clients to make and maintain significant recoveries. In contrast, clients with mild and moderate disorders have been shown to benefit significantly from psychological intervention through the Better Access initiative, which comes at comparatively minimal expense for Medicare. *Dollars spent on mild or moderate disorder are likely to be more effective than those spent on severe disorder.*

Provision of effective services for mild and moderate mental health disorder provide positive outcomes not just for the clients themselves, but also for their families, communities and the wider economy. I can think of many examples of this ripple effect in the clients I have seen through Better Access. For example, effective treatment of depression or anxiety may in turn allow a client to (i) remain in employment rather than withdraw; or (ii) better care for their children (thus enhancing the mental and physical wellbeing of those children); or (iii) repair and sustain their couple relationship; or (iv) continue in their role as a carer for someone with a disability, dementia etc; and so on. In turn, the follow-on impact for the economy and the reduction of other government expenditure is clear, for example maintaining productivity and avoiding further costs from other government services in health, housing and other family services. *Government funding that targets mild and moderate mental disorder (as Better Access has been doing effectively) has far-reaching benefits for clients and their communities; reducing Better Access will be detrimental to many.*

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(b) Changes to the Better Access Initiative, including the reduction of the number of allied mental health treatment services

A substantial number of the clients I see in my private practice come through Better Access. Since its inception in 2006 I have observed it to be a popular and successful government initiative, enabling clients who would not otherwise access psychological service to do so, quickly and locally. I am very concerned about the reduction of sessions from 18 to 10 per year. As a psychologist working ‘on the ground’ in Better Access, I can say that, quite simply, ten sessions will not be enough to achieve substantial or sustainable treatment results for many clients. In six to ten sessions clients may be able to address symptoms and superficial concerns but will not have the opportunity to develop insight into the triggers and context of their difficulties, thus leaving them likely to relapse and for problems to recur or worsen – requiring further cost to treat. *Cutting back treatment sessions in Better Access will turn a successful and effective government mental health initiative into a superficial scheme which will frequently fall short of providing the meaningful treatment outcomes it currently enables.*

In fifteen years of practice I do not see clients continuing to attend psychological counselling as a luxury, or where there is no significant need to do so. It doesn’t happen. If the available number of sessions is left at 12 / 18, the number of sessions required can appropriately be decided between the client, the treating psychologist and the general practitioner, rather than dictated by an arbitrary cut-off.

(e) Mental Health Workforce issues, including the two-tiered Medicare rebate system for psychologists

The current two-tier system of rebates is unfair and discriminatory in that it favours Clinical Psychologists over other specialist psychologists without good reason. Counselling Psychologists have the same level of post graduate study and supervised clinical experience as Clinical Psychologists (6 years plus supervised clinical experience), and must demonstrate competence in mental health assessment, diagnosis, and psychotherapy to gain membership of the College. As an endorsed Counselling Psychologist under the current system, Medicare enables me to provide only ‘focused psychological strategies’ for clients (at the lower tier rebate), even though I am qualified, experienced and competent to provide more substantial ‘psychological therapy’. This is unfair, unhelpful to clients, and presents something of an ethical dilemma if I am to provide the most effective services in my repertoire to the clients who present to me. It also reduces the availability of ‘psychological therapy’ for clients who need it when the workforce of Counselling Psychologists is well equipped to meet this need. *The top tier of rebate, ‘psychological therapy’, should be widened to include other sufficiently skilled clinicians: most obviously, endorsed Counselling Psychologists.*

In summary:

1. Maintain funding for Better Access, because effectively targeting mild and moderate mental disorder is a priority and will reduce government expenditure in other areas
2. Decreasing the number of allied health sessions from 18 to 10 will reduce the effectiveness of Better Access
3. Widen the top tier of rebate to include other appropriate specialists e.g. Counselling Psychologists

Regards,

Helen Fitzhardinge
Registered Psychologist (Counselling)