Submission to the Senate regarding the Commission of Audit: potential proposed cuts to services including changes to Mental Health and, in particular, the Better Access Initiative

By

Siouxsie Venning
BA (Hons), M. Psych (Clin).

January 30th 2014

Dear Senators and interested parties,

My name is Siouxsie Venning and I am a Clinical Psychologist in South Australia, practicing in Morphett Vale and Adelaide. I also practice as a visiting psychologist in Lismore, regional New South Wales. I have some concerns re the Federal Budget, and any potential proposed changes to the Medicare rebate system for psychologists and it's impact on Mental Health. I also have concerns regarding any cuts or co-payments to the Medicare system in general, as well as any proposed cuts to Mental Health. I was hoping to get both federal and state politicians to consider the impact, as I believe it has implications for both state and federal funded mental health. I also believe that the public should be made fully aware ***any*** proposed cuts, such that the people who are most likely to be affected by cuts are able to lodge submissions and have a fair hearing. It would be both naïve and arrogant for any government or commission to assume that they have the full knowledge of the on the ground impact of cutting services without the input of unbiased specialists in the field, patients, consumers and the Australian Public.

As I was only informed of the opportunity to lodge a submission, today, January 30th, I will be relatively brief. Attached is my previous submission to government regarding Better Access, which provides more detailed arguments on the impact of cuts to Mental Health. Many of the predictions outlined in these arguments I have observed first hand since cuts to the Better Access. I believe this has implications for any further cuts to Mental Health services, which might be proposed by the current committee.

I will firstly discuss the impact of reduced access to Mental Health Services, and draw on observations made over the past two years. These observations are made in relation to the Mental Health and the Better Access Initiative, which was subsequently significantly reduced by the, then Labour Government.

Certainly, since the reduction of Better Access sessions from 18 to 10 per year, I have seen clients remain ill and unproductive for longer periods. I have seen clients suffer from more disability, health problems, financial hardship, relationship difficulties and job loss than would likely have been the case if people were able to access an adequate number of sessions. I have seen a greater cost to the community in terms of people needing to access welfare payments, an increase in applications for the Disability Pension, an increase in Workcover cases, an increase in chronic health issues and an increase in people suffering from addiction issues (both in relation to substances and gambling). I believe that this is, at least in part a consequence of a reduction in Better Access funding, a reduction in funding for community programs, a reduction to both Federal and State mental health services, and the average person feeling a sense of powerlessness.

The new government has inadvertently heightened this sense of powerlessness by keeping people in the dark about policy and threatening to

do away with any media organizations (ABC, SBS) and/or programs (the Environmental Legal Service, the current Australian School Curriculum) that encourage critical thinking based on facts or which seek to provide unbiased or alternative points of view. It is a well-known fact in psychology that uncertainty and lack of information heighten anxiety. It also often follows that when people feel anxious or powerless mental health problems, substance misuse, violence and crime increases and that productivity decreases.

I would encourage this inquiry to advocate for the mental health and wellbeing of the public in the following ways:

1. By opposing any cuts to health and mental health services which are already struggling, and which are likely to see increased demand due to treatment constraints which were implemented by the previous government, State governments, and potentially this government, as well as due to uncertainty and powerlessness experienced by much of the population due to economic and political factors.

2. By opposing any idea of co-payments for Medicare, which will have the likely effect of encouraging people (particularly those struggling financially who ironically tend to be the most effected by health/mental health issues) to delay or avoid treatment. The potential consequence is an increase in disability, mental health issues, substance use, spousal and child abuse and physical health issues and a decrease in productivity. It is likely to increase complexity or conditions meaning that conditions will take longer to treat, people will be disabled for longer and chance of recovery will be reduced. It is also likely to increase demand on the Welfare, Legal and Health Systems, thereby actually costing more in the short, medium and long-term than it saves.

3. By opposing cuts to government funded media organizations as well as organizations that provide legal and advocacy services. In a democratic country every body should be able to make up there mind based on facts and transparency rather than secrecy and propaganda. In a democracy justice and advocacy should be readily available to everyone, including the most vulnerable. Their economic assets should not dictate one's access to justice, advocacy, free speech and information.

Attached is my submission to Senate Inquiry (July, 2011) regarding potential proposed changes to Mental Health, in particular the Better Access Initiative.

If you require any further information, please do not hesitate to contact me.
Yours Sincerely,

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Submission to the Senate regarding proposed changes to Mental Health, in particular the Better Access Initiative

By

Siouxsie Venning
BA (Hons), M. Psych (Clin).

July 18th 2011

Dear Senators and interested parties,

My name is Siouxsie Venning and I am a Clinical Psychologist in South Australia, practicing in Morphett Vale and Adelaide. I also practice as a visiting psychologist in Lismore, regional New South Wales. I have some concerns re the Federal Budget, the proposed changes to the Medicare rebate system for psychologists and it's impact on Mental Health. I was hoping to get both federal and state politicians to consider the impact, as I believe it has implications for both state and federal funded mental health. I also believe that the public should be made fully aware of this, particularly as the Labor Government is using Mental Health Reform as a major platform to sell this budget. I am very concerned new initiatives threaten access to adequate services for the most vulnerable. I am equally concerned that changes to rebates may mean an end to psychologists being able to assist people on low incomes as bulk-billing becomes largely unfeasible. I am also concerned that professional territorialism limiting psychology positions within the public service and onerous training/professional development requirements may herald the end of the psychology profession.

Please take the time to read this document in its entirety, as I believe it offers substantial insight into the issues being investigated by this committee. More importantly, it also offers some valid solutions.

In particular my submission seeks to address:

1. **Changes to the Better Access Initiative, including**

a) The impact of changes to the number of allied mental health treatment services for patients with mild or moderate mental illness under the Medicare Benefits Schedule
b) Services available for people with severe mental illness and the coordination of those services

2. **The two-tiered Medicare rebate system for psychologists:**

a) The impact on the adequacy of mental health funding and services for disadvantaged groups
b) Workforce qualifications and training of psychologists
c) Workforce shortages

I will argue that under-treatment of complex cases and marginalized groups can thwart recovery. Thus, reducing the amount of sessions per year is inevitably counter-productive from both a health and economic perspective.

I will assert that existing government services and their coordination, base much of their staffing on professional territorialism rather than the best interests of the clients. Managers are increasingly more likely to revise multidisciplinary positions such that they employ workers from their own discipline rather than employing staff that are trained specialists in dealing

with complex mental health issues and dual diagnosis.

I will discuss the potential impact of reducing the rebate for Clinical Psychologists in terms of impeding access to psychological services for the disadvantaged, differences in qualifications and training and potential workforce shortages.

I will include some solutions to the issues raised and conclude by providing an economic rationale for supporting Medicare rebates and private practice.

Changes to the Better Access Initiative

- **The impact of changes to the number of allied mental health treatment services for patients with mild or moderate mental illness under the Medicare Benefits Schedule.**

As you are aware, the Gillard Government plans to cut Medicare visits to allied health (psychologists, social workers, etc) from 12 visits, with a maximum of 18 under exceptional circumstances down to 6, with a maximum of 10 services. The Gillard Government has touted that reallocating funds the ATAPS Scheme will fill the gaps. ATAPS is a program currently accessed through the Division of General Practice to assist people with mental health issues, excluding substance related issues. Psychologists for ATAPS are usually employed or accessed directly by the Division of General Practice, where Medicare Psychologists are in Private Practice and accessed directly by clients. Many under-funded non-government services also rely on referring to Medicare Psychologists to further bolster service delivery. The Gillard Government has suggested that the reduction in Medicare sessions will mean that Private Practitioners can focus on people with "mild" mental health issues, whilst ATAPS, picks up the more severe. Sounds great in theory but will that be the case, or will people be less able to access an appropriate service. Arguments against reduction of sessions are as follows:

1) People with long-term, multiple issues or complex issues require more sessions initially.
Under-treatment wastes resources and causes the **“band aid effect”,** whereby people’s initial symptoms decrease only to reemerge at a later date either just as intense, worse or in a different form. Further, prematurely finishing treatment can exacerbate mental health issues or cause the client to put off further treatment. I.e.: A patient may begin to think, “because it didn’t work last time, it must be a failing of either the himself/herself or the treatment so what’s the point in trying to fix it.” This may increase negative thinking, leading to further relapse and decrease self-efficacy.

Limiting sessions to 10 per year is fine if you are seeing clients who do not have major or multiple issues. However, many Medicare funded psychologists see a varying component (depending on where the practice is) of highly complex clients. Certainly my cases are equally split between people with moderate mental health issues and highly complex clients. These clients are all bulk-billed, such that they are not out of pocket. Many of these complex

clients present with substance issues, domestic violence, chronic or terminal illness and/or multiple mental health issues. A lot of these clients, particularly the domestic violence and/or substance use are unlikely to present to a "centre" or formal service until the problem becomes quite severe. However, they seem to be readily coming into non-stigmatized professional rooms, before their whole lives are off the rails. It costs a lot less in time, loss of productivity, money and resources to intervene early rather than later.

2) Many marginalized groups avoid labeled government services or even places with multiple services due to a number of factors including stigma, fear, not understanding their condition or which service to access (e.g.: in denial re domestic violence/substance abuse but recognizing anxiety or depression), anxiety (social anxiety, agoraphobia) or having multiple issues which would require multiple referrals to different agencies.

Accordingly, having to present to Super Clinics or ATAPS may reduce the likelihood of the most vulnerable and/or difficult to engage groups receiving treatment.

Studies reported by our overseeing union, the Australian Psychological Society demonstrate that, unlike government claims, Better Access is quite effective in reaching marginalized groups, particularly youth, men and people in regional areas. Certainly from my experience I saw both young people and older men with undiagnosed depression, alcohol issues and anger issues that attended therapy for the first time, due to the non-stigmatized availability of accessible services. I also work with people in regional New South Wales, who have limited access to services. Moreover, via Medicare clients can be seen for multiple issues without unnecessarily being referred on to multiple services, which otherwise often happens due to services being funded to deal with some issues and not others. Being able to see a clinical psychologist often means a client can see the same person with expertise in mental health, domestic violence, substance abuse, pain management, relationship issues, parenting issues, etc. This effectively makes it easier for a client to address multiple issues and fully recover. In contrast, having to chase up multiple services or engage with multiple counsellors may result in the client either being unable to access relevant services or losing motivation for treatment. Intuitively, one could speculate that this would lead to partially treating a problem or underlying cause, leading to a greater likelihood of relapse down the track.

Axing this program (or is it just limiting it at this stage) is not really a good look for a government who on one hand seems to be butchering a program that provides easy access to psychological help with minimal stigma, when on the other hand it is heralding early intervention as a priority. As for ATAPS, it could be a good option, but the skeptic in me wonders if it's just a way of 1/ phasing out Better Access through Medicare altogether and 2/ shifting any criticism for the under-funding of ATAPS from the government themselves to the Divisions of GP's and/or localized Super Clinics. Certainly the Division of GP's must have had some qualms about this, and tenders have now gone out for other "players" to tender for the Super Clinics and control of ATAPS funds.

Even ATAPS counselors and psychologists and the Divisions of GP's have no idea how ATAPS, its number of sessions, and it's funding is going to change at this time. Certainly, many counselors who work with ATAPS are not clinical psychologists, thus are not subject to 4-8years of specialist training in psychology plus rigorous professional development and ethical requirements. I guess only time will tell if the clients will benefit or not. What really concerns me is what happens to people who need help now, while we are waiting to find out!

Similarly, time will tell if marginalized groups are willing to access ATAPS and/or Super Clinics, or if their issues fester and spread. For example: imagine a young man with untreated depression and alcohol issues avoiding a Super Clinic or "treatment centre" and going on to develop anger issues, perpetrate domestic violence, increase substance use, become unemployed and struggle with finances and criminal issues. Am I exaggerating? Unfortunately, this was a regular occurrence pre Better Access and still occurs today. Having worked extensively in South Australian Drug and Alcohol Services and the Magistrates Mental Health Diversion Court, I can attest to the fact that **only those who were hitting "rock bottom" on a number of levels could be seen before Better Access was available.** However, I have had many men present with anger, substance, depression and anxiety issues since Better Access started, and they have gone on to address issues and increase their own and their family's health and well-being.

3) Under-treatment or inadequate treatment by a lay-person or non-specialist/generalist workers often costs the community, the patient, the family and the government more.

Many of my clients have long standing mental health, drug and alcohol or domestic violence issues who did not access government run services due to stigma, long waiting lists or having multiple issues, thereby being referred from agency to agency. These clients would not be able to manage with 6-10 sessions, during the initial year of 2 of treatment. Many are notoriously hard to engage but when you do will make great gains in health and well being. They would struggle with seeing multiple clinicians, and would be at risk seeing a non-specialist counselor. There is a reason psychologists receive between 4-8 years of specific psychological training. To send many clients to a non-specialist counselor would be akin to allowing someone with a first aid certificate perform a surgical procedure. Very risky...

For Example: One of my clients had been in and out of medically based drug and alcohol services trying to address a heroin addiction for a number of years, with little improvement. After 3 years of psychological intervention, he has overcome a 20 year drug addiction, underlying anxiety and depression, an unhealthy relationship and has attained fulltime employment in a well paid position. The moral: medication and generalist counseling may be a cheap alternative but it **doesn't fix underlying problems** or teach the living skills necessary for a full recovery.

4) Reducing the number of sessions or the rebate and therefore the bulk-billing capacity of the Better Access Scheme will limit access to services for Marginalized Groups.

There are a number of **marginalized groups that would be disadvantaged** by these new proposals. I have a worked with a number of women who have initially presented with anxiety, depression or substance related issues, who have later disclosed being subjected to **domestic violence**. Without Better Access many of these women would have slipped through the cracks. The nature of domestic violence is such that they either doubt their own judgment or their ability to access assistance. Moreover, many women who have been exposed to generational violence simply accept this as "normal", and therefore would be unlikely to even recognize abuse as unacceptable or their response to violence as an expected consequence. Accordingly, they would be unlikely to present to a domestic violence service, but do present to their GP and a psychologist to get the symptoms treated, whereby they are in a position to access help for the cause.

Young people with developing mental health issues, impulsivity, legal or substance issues also have readily presented to my service and have progressed well, but would not have the finances to pay a gap for services. **Men** also have accessed my service, as have some **migrants** from non-English speaking backgrounds. I believe many of these groups may simply not present to a formalized organization (even a Medicare Local hub) due to potential stigma and also the nature of behaviour change being subject to motivational shifts. I.e. If it's too hard or too scary people will hope for the best and stay in an unhealthy situation. Better Access to psychologists and GP's makes it safe and easy to access help.

I believe the key to disadvantaged people being able to access services is to make it a stipulation that any psychologist accepting Medicare must agree to **bulk-bill** those on a health care card. Certainly, I always bulk-bill people suffering financial hardship, irrespective of whether they have a health care card or not. I believe this should be viable for most Clinical Psychologists, if the Medicare rate is not reduced by a third, as is being considered.

5) Better Access to Psychological Services aids Productivity and reduces long-term costs.

The Better Access system also seems to be helping **productivity**. During my four years being a private provider I have had many people access my service due to **workplace issues** (bullying, burn out, chronic health and pain). These people have not wished to be subjected to the stigma and requirements of lodging a formal complaint with Workcover, but have instead sought to deal with their issues with a private clinician and, literally, get on with the job.

Moreover, I have also worked with **Carer's** of the disabled and chronically ill, Foster Carers and grandparents parenting grandchildren, all of whom struggle with little support. I wonder how many would have just given up work or their Carer's duties if affordable, non-stigmatized help had not been available. These issues are often not something that can be dealt with in 6-10 sessions or by a person with non-specialist qualifications.

The **cost** of people not receiving adequate treatment, access to non-stigmatized services and early intervention are already being borne out in the community. It can be demonstrated by the increased pressure on our hospitals, health services, community agencies, charities, police and correctional services. It can be demonstrated by the increase in domestic violence, substance use, mental health issues, physical health issues, poverty, child abuse, homelessness and crime. These are the follow on effects from **"Economic Irrationalism"**: The mistaken belief that you can save money by under-funding crucial services without the negative follow on effects from inadequate resourcing actually costing the economy (and the community) more than the estimated potential "savings".

Early intervention works, and early intervention is what the Better Access system offers. We are a country that needs people to work, to address their health issues, take on Carer responsibilities for the elderly, grandchildren, the disabled and the chronically ill. Imagine what will happen when all these paid and voluntary workers reach the end of their tether due to lack of support. When you vote to either uphold or decline the budget proposal ask yourself one thing …Is it worth the risk?

Solution

The number of sessions for a client per year should be based on need, not an arbitrary number. If sessions must be limited, base it on severity of symptoms as measured by a standardized test such as the DASS (Depression, Anxiety and Stress Scale), rather than on Economic Irrationalism.

Services available for people with severe mental illness and the coordination of those services

I will now address my concerns about the services and coordination of services for people with severe mental health issues.

As previously mentioned, problems with services for severe mental illness include stigma, long waiting lists, inadequate levels of staffing, generalised training instead of specialised staff, clients with multiple issues having to be referred to multiple agencies due to red tape, territorial funding and a large propensity of generalist or non-specialist staff.

Clinical psychologists are the only profession (other than psychiatrists) who study psychology for the whole period of our degree (now between 6-7 years), yet we have been slowly edged out of the public service over the past few years, by generalist workers. These workers often have a little bit of counseling experience. During my time in the Public Service I was expected to provide them with training in counseling and take over the "tricky" cases, when it all got too hard. Psychologists and these other workers (outside the discipline) get paid roughly the same amount yet positions in the health industry are becoming less and less for psychologists.

Accordingly, it seems counterintuitive for Clinical Psychologists, workers with the most specialist training (other than psychiatrists), to be the least represented in mental health and drug and alcohol services. This inadvertently means that often the more severe your mental health issue is, the less likely it is that you will be treated by someone with specialist training.

The reality is that most nurses receive minimal specialist training in mental health. Social workers do receive more training in mental health and concordant dysfunctions, though both certainly receive less than 6 years. Yet the services, which target those with the most severe mental illnesses, tend to under-utilize Clinical Psychologists: specialist workers, whose training specifically targets mental health, behaviour change and motivation.

It appears a **poor use of resources** to limit psychologists to "mild" to "moderate" mental health issues. In order to address this I would like to see a stop to "professional exclusion" when government jobs are advertised. I believe this, at least in part comes about by certain professions dominating management positions, and thus, excluding or limiting positions for professions outside their own. Therefore, service coordination appears to be largely dictated by **professional territorialism** rather than in the best interest of the service or the well-being of the clients. Certainly, in South Australia both Mental Health Services and Drug and Alcohol Services are deliberately excluding psychologists from being able to apply for a variety of multidisciplinary positions. I would like to see this rectified so that the most vulnerable and complex clients have access to specialist treatment.

The two-tiered Medicare rebate system for psychologists

The impact on the adequacy of mental health funding and services for disadvantaged groups.
Bulk-billing will become untenable and those most in need will have reduced access to services.

As a social justice advocate, my greatest concern about changes to the two-tiered system is that it will make the capacity to bulk-bill clients untenable. In the case of my own practice I work in a lower socio-economic area, where the majority of my clientele (68% over the past 6 months) are financially disadvantaged clients who are bulk-billed. Bulk-billing is available irrespective of whether they have a health care card or whether they are a member of the ever growing "working poor". The clients who are not bulk-billed are self-identified as not being under financial hardship, and only pay a $30 gap.

With the higher Medicare rebate I am able to offer a high quality service, with little or no cost to clients. I am also able to offer additional free services to clients in dire need, in an effort to provide holistic, effective health-care.
For example:
a) I attended court as a witness on behalf of female client who had been subjected to domestic violence when her ex-partner attempted to use the

Family Court System as retribution for her having the courage to leave. As the primary witness I was able to give testimony, which reduced the likelihood of their young daughter being exposed to potential abuse and trauma.
b) I regularly provide 2 hour home-based counseling to a lady suffering from a debilitating terminal illness, and am able to do so at no cost to her even after Medicare's 18 sessions have been used for the year.
c) When warranted I can supply support letters for clients in relation to housing, financial assistance, legal issues, etc.
d) I can afford the time to locate and access services which will assist clients, thereby ensuring a holistic approach to health and well-being.

Certainly, if the rebate for clinical psychologists is reduced I will have to charge a gap and/or reduce many of these extra services that assist clients to move forward more quickly.

Personally, my practice, which caters to those most in need and is based in a lower-socio economic area, will either have to change significantly or close down. A likely consequence being that I will be treating people who can afford to pay rather than treating disadvantaged clients most in need. This is likely to result in me assisting higher income groups with weight loss and study techniques rather than providing potentially life-saving services to lower income groups with domestic violence, mental health and substance abuse issues. Moreover, it is likely that many psychological practices will need to relocate to higher socio-economic areas in order to survive. This means that the most vulnerable people and those in lower-socio economic areas are probably going to be those least likely to have access to psychological services.

Solution
A potential solution to avoiding these problems may be by indexing the Medicare rebate to practice location. I believe this system is currently used with GP rebates. Here, those practices located in higher-socio economic areas would receive a lower Medicare rebate, as clients are generally more able to pay a gap. Those practices located in lower-socio economic areas or endorsed as working in partnership with non-government organizations/charity programs such as Salvo-Psych (Salvation Army and Psychology partnership) or Gold Coast Drug Council would receive a higher Medicare rebate. This would enable psychologists in private practice to continue to offer bulk-billing to those most in need, who are usually the least likely to be able to afford a service.

Workforce qualifications and training of psychologists
It is generally recognized in most professions that those who spend longer in education pursuing a profession or specialty have greater expertise due to more specialized training. Thus, the extra years spent as a low or no income student are usually rewarded by higher wages than people who have not pursued extra training. If Higher wages for Registered Nurses vs. Enrolled Nurses or rebates for Specialist Doctors vs. GP's are accepted, then why are

higher rebates for Clinical Psychologists vs. Generalist Psychologists being questioned?

As previously mentioned, clinical psychologists are the only profession (other than psychiatrists) who study psychology for the whole period of the degree (now between 6-7 years). Until 2010 in order to warrant endorsement as a Clinical Psychologist you must have completed 6 years of full time University study, along with the Full-time equivalent of 1 year of supervised clinical work, (40hrs supervision & 40hrs active professional development). The requirements have recently been increased to either 7 years University study with 1year FTE of supervised work or to 6 year of University study with 2 years FTE of supervised clinical work. These extra years of study necessarily involve financial sacrifices in that students generally do not receive a wage and incur extra HECS/HELP fees with each year of study.

In contrast, until 1994 generalist psychologists only had to complete 4 years university study in order to register. Post 1994, generalist psychologists were required to do 4 years study plus 2 years supervised work. Most commonly the 2 years of supervision took place whilst they were employed, receiving a wage and overseen by a psychologist within their agency of employment.

In most health professions the option of further study brings with it more initial financial and personal sacrifice but with greater specialization and financial rewards down the track. We would not expect a Specialist Doctor who studied for substantially longer than a GP to get an equivalent wage or Medicare rebate. Likewise, I fail to see the justification that warrants a Clinical Psychologist who has spent 6-7 years in non-paid training, get the same Medicare rebate as a generalist psychologist, who has had the opportunity to receive wages throughout their last years of training, and may or may not have been subjected to the same level of standardized optimum training which a Master of Clinical Psychology provides.

Solution

As a psychologist I strongly believe that a psychologist with even a four year degree which primarily focuses on psychological intervention, should receive a higher Medicare rebate than another health profession that has not had as long specifically receiving training in Mental Health, motivation and behaviour change. After all Mental Health, motivation and behaviour change are the primary goals of the Better Access System.

However, I understand how other health professions with 4 years training may feel justified in receiving the same rebate as a generalist psychologist with 4 years training. Accordingly, I feel the two-tier system of funding whilst not ideal, is justified. However, I do believe that those who have a 4 year psychology degree should be afforded an accessible option for further study to upgrade to a clinical level. I believe greater specialization can only benefit clients and ensure that the public and the vulnerable have access to services that meet their needs safely and adequately.

Workforce shortages

As previously mentioned, I have some concerns as to the general trend within the health system to replace specialty positions with generic health workers, primarily due to what I have labeled “professional territorialism”, rather than in the best interests of clients.

This, along with the new onerous professional development requirements and the new study requirements in order to be able to be sanctioned as a Clinical Psychologist, make me wonder why any new students would bother- just be a generalist worker in 3 years (or under) if you want to “do counseling”. And this is without even considering the proposed changes to Better Access and the likely dumbing down of ATAPS, as Super Clinics try to balance adequate health care with probable under-funding.

The consequence: Huge workplace shortages of specialists in mental health, as people who wish to provide counseling, choose shorter courses which offer more generalist health training and less development of the specialist skills needed to adequately treat complex issues. The consequence for clients: superficial treatment outcomes. The consequence for the health system: a “revolving door” as clients who have been “patched up” return with the same issue (perhaps taking different forms), again and again.

Solution

In order to address this I would like to see a stop to “professional exclusion” when government jobs are advertised. I believe this, at least in part comes about by certain professions dominating management positions, and thus, excluding or limiting positions for professions outside their own. Therefore, service coordination appears to be largely dictated by professional territorialism rather than in the best interest of the service or the well-being of the clients. I would like to see this rectified so that the most vulnerable and complex clients have access to specialist treatment.

Private Practice costs the Government Less. Reducing the rebate for Clinical Psychologists will cause many private practices to either fail or be unable to provide a service to the most needy. This will increase the demand on government services, thereby costing the government more.

With report writing requirements, liaison with mental health, emergency and support services, responding to mental health emergencies, mandatory reporting to mental health triage or child protection, and mandatory professional development requirements, I work an average of 35 hours per week. My earnings (after practice expenses) for the 2010-2011 financial year were $62267.48 before tax, and without including my HECs debt (which incorporates 6 rather than 4 years of study). This is with no sick leave, long service leave, or holiday leave. Prior to private practice I was working for a state government run health service and earning approximately $43200 for a 21-hour week (35 hour equivalent $72000), no after hours responsibilities, with Long Service Leave, Sick Leave, Study Leave and Holiday Leave.

The reason I chose to go into private practice, despite the pay decrease and the hour increase was that I wanted to be able to spend more face-to face

time with clients. I also wished to spend less time in meaningless meetings or training staff from other disciplines with little counseling training how to do my job. Due to having flexibility I am able to see more clients and provide them with a better service than I was within a government agency. Moreover, my services as a Private Practitioner are costing the government less than they would as a government employee.

By my calculations if the Medicare rebate for clinical psychologists were to decrease from $119.80 to $81.60, I would earn roughly $41511.33 for a 35 hour week, with no Sick Leave, Holiday Leave, Long Service Leave, Superannuation or Study Leave. Accordingly I would have to strongly consider either closing the practice or cease bulk-billing with a view toward tailoring services to fairly stable clients with economic means, rather than vulnerable clients, with complex issues and little financial means. I got in this business to make a difference to those most in need. Please consider the impact on these people when you consider changes to the Better Access system.

In conclusion, I hope you will consider the points raised. The implications of under-funding and under-treatment; the implications for bulk-billing and reducing service access to disadvantaged groups; the implications for the potential demise of psychology and the potential (and I believe equitable) solutions provided.

If you require any further information, please do not hesitate to contact me. Until August 9th, I am best contacted via my mobile phone.

Yours Sincerely,

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N.B: Please see Appendix 1 for additional relevant information.

Appendix 1

A Snapshot of the People Most Effected by Your Decisions

List of Bulk Billed Clients and their Diagnoses:

Client 01: Past trauma, depression, anxiety, significant financial hardship, Work place issues.
Client 02: Chronic illness, pain, depression, disability, significant financial hardship, accommodation issues.
Client 03: Carer for Mentally ill Mother, Step Brother and Step Father. Work place issues, anxiety.
Client 04: Parenting Issues, depression and anxiety.
Client 05: Domestic violence, parenting, anxiety, personality disorder.
Client 06: Past trauma, depression, previous suicide attempts, domestic violence, anxiety.
Client 07: Domestic violence, social phobia.
Client 08: Post Traumatic Stress Disorder, past alcohol addiction, anxiety, depression, eating disorder.
Client 09: Depression, anxiety, learning disability.
Client 10: Potential prodromal psychotic illness, gender issues, social anxiety, past trauma.
Client 11: Victim of Crime, PTSD, anxiety, depression, work issues.
Client 12: PTSD, domestic violence, alcohol and substance issues, eating disorder, anxiety, depression.
Client 13: Depression, work issues.
Client 14: Social phobia, depression, severe anxiety affecting cognition and memory, work and vocational issues.
Client 15: Childhood trauma, Carer for mentally ill son, depression.
Client 16: Alcohol addiction, social anxiety, bipolar disorder.
Client 17: Work place trauma, depression, anxiety, previous domestic violence related trauma.
Client 18: Work place issues, childhood trauma, same sex issues, anger, anxiety and depression.
Client 19: Workplace trauma, PTSD, childhood and ongoing trauma caring for mentally ill parents, post natal depression and anxiety.
Client 20: Childhood trauma, domestic violence, PTSD, workplace issues, significant financial hardship.
Client 21: Alcohol addiction, domestic violence, childhood trauma, anxiety, depression, significant health issues.
Client 22: Social Phobia, generalised anxiety disorder and specific phobia.
Client 23: Agoraphobia, generalised anxiety disorder, childhood trauma.
Client 24: Former Heroin addiction, social anxiety, depression.
Client 25: Chronic illness and pain, depression, past domestic violence, anxiety and significant financial issues.
Client 26: Carer for Mentally ill spouse, foster carer for two children, depression, health issues, significant financial issues.
Client 27: Social Phobia, grief, generalised anxiety disorder, work issues.
Client 28: Relationship breakdown, grief and loss.
Client 29: Domestic violence, work and vocational issues, anxiety.
Client 30: Domestic violence, social phobia, generalised anxiety.

Appendix 1: continued

Client 31: Chronic illness, work and vocational issues, marijuana use.
Client 32: Carer for 2 intellectually disabled children, childhood trauma, depression, social anxiety.
Client 33: Domestic violence.
Client 34: Post traumatic Stress Disorder, trauma-related epilepsy and resultant cognitive, behavioural and emotional difficulties.
Client 35: Victim of crime, previous domestic violence, depression, anxiety.
Client 36: Workplace injury and trauma, pain, depression and anxiety.
Client 37: Terminal illness, pain, depression, anxiety.
Client 38: Depression, anxiety and Paranoid Personality Disorder.
Client 39: Chronic fatigue, depression and anxiety.
Client 40: Grief, long-term trauma, significant ongoing health issues.
Client 41: Grief, return to work issues.
Client 42: PTSD, childhood trauma, depression, alcohol issues.
Client 43: Workplace issues, PTSD, anger, previous suicide attempts, depression and anxiety.
Client 44: Multiple Sclerosis, pain, depression, domestic violence.
Client 45: Long-term anxiety, recovering from workplace bullying.
Client 46: PTSD, long-term trauma and unresolved grief.
Client 47: PTSD, childhood trauma, return to work goals, domestic violence and anxiety.
Client 48: Marriage breakdown, grief.
Client 49: Amphetamine use, social anxiety.
Client 50: Childhood trauma, marriage breakdown, anger issues, marijuana use.
Client 51: Amphetamine use, anxiety, depression, relationship issues.
Client 52: Bipolar, marriage breakdown, ex-partner's gambling addiction.
Client 53: Childhood trauma, PTSD, agoraphobia, diazepam addiction, depression, self-harm.
Client 54: Child's amphetamine addiction, Carer for ill partner and mentally ill parent, depression, alcohol overuse, previous suicide attempt.
Client 55: Victim of crime, PTSD, severe anxiety, significant financial hardship, carer for a number of family members.
Client 56: Pain, disability, domestic violence, depression, grief.
Client 57: Gambling, generalised anxiety disorder, long-term Carer for mother and brother with significant mental illnesses.
Client 58: Carer for mentally ill husband, depression, alcohol abuse.
Client 59: Childhood trauma, workplace issues, trichillomania, generalised anxiety disorder.
Client 60: Domestic violence, Obsessive Compulsive Disorder, depression, Paranoid Personality Disorder.
Client 61: Chronic pain, Paranoid Personality Disorder, depression, chronic suicidal ideation.
Client 62: Social anxiety, depression, learning disability, Carer for child with a disability.
Client 63: Generalised anxiety, relationship difficulties, significant financial hardship.
Client 64: Depression, suicidal ideation, agoraphobia, previous substance.