

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

4 August 2011

Re: Senate Community Affairs Committee Inquiry into the Government's funding and administration of mental health services in Australia.

I am a registered psychologist of more than 20 years experience, with *dual endorsements in Clinical Psychology and Counselling Psychology* under Psychologists Board of Australia and AHPRA. I hold a Masters degree in Counselling Psychology, and an honours degree in Clinical Psychology. I have worked in private practice in Perth, WA for the past 10 years.

I wish to make a submission to the above Inquiry, with particular reference to the *Better Access Initiative* and proposed new measures following the 2011-2012 Budget changes. In particular, I will comment on Items (b)(ii), (b)(iv), (c), (d), (e) in the terms of reference for this Inquiry, under the 2 main headings:

- 1) Proposed Reduction in Number of Sessions
- 2) Review of the two-tiered Medicare rebate system for Psychologists

I will confine my comments to the provision of mental health care services by Psychologists, as this is my profession.

Issue 1) Proposed Reduction in Number of Sessions

Despite a very positive review of the successes of the Better Access initiative, the government has seen fit in the recent national Budget to reduce the number of allowable sessions for psychological treatment from 12 (standard) or 18(exceptional circumstances), to 6 initially with a maximum of 10 annually.

The proposal to cap the number of sessions at 10 effectively halves the length of treatment available to a person under *Better Access*. The 10 session cap limits psychological therapy to half the recommended amount for many relatively uncomplicated psychological conditions. Research from both the *Australian Psychological Society* and Harnett et al. (2010) shows that around half of the people who receive psychotherapy via *Better Access* will need more treatment than they have received in the annual Better Access allowance.

Focusing on psychosis and severe disorders is very important, however, it is only part of the problem. The other imperative is to keep investing in those areas that work already. Under the new proposals Mental health services would be artificially split by claiming that the *Better Access* system is for mild disorders and ATAPS is for severe disorders. The evidence has repeatedly shown that 80% of people who access the *Better Access* initiative have moderate to severe mental health issues. Splitting up mental health services in this way is baseless.

- Changes to the *Better Access* initiative amount to dismantling a system that has been shown to work. The Medicare review indicated that *Better Access* was cost effective, far exceeding expectations about the value of mental health care

provided in this program. Introducing these severe new restrictions will have a measurable impact on the quality of care that can be provided, and in doing so, will do immeasurable damage to an important component of mental health care in Australia that is working just fine the way it is!

- Psychological outcome research demonstrates that capping therapy at 10 sessions is unrealistic. Even when we look at figures from research conducted by the government, we find support for the length of psychological treatment needing to be closer to 20 sessions. For example, the Department of Health and Ageing funded a review of psychological interventions conducted by the Australian Psychological Society, showing that the minimum standard treatment is 12 sessions, and that most psychological interventions for depression and anxiety span 15-20 sessions.
- Professor John Mendoza has claimed that most people don't use more than 10 sessions in the *Better Access* system. If this is true, then why not let that decision be made between the client, their psychologist, and their GP? If people are not accessing more than 10 sessions, then it will not cost any additional funds to allow the level of psychological care be decided between the individual and the mental health professionals they consult with.
- In my practice, of my Better Access patients, about one third use up to 7 sessions, about 50% use between 8-12 sessions, while about 15%-20% require the full 18 sessions. **This 20% of more severe and complex cases really do need access to 18 sessions, or more, to allow positive and sustainable treatment outcomes to be achieved.** In almost all cases, these patients had not been able to access the necessary, appropriate treatment elsewhere in the mental health system. **The new proposal threatens to disenfranchise such vulnerable patients who at last have been able to access professional psychological treatment through the private sector, with the help of Medicare funding.**
- Capping the number of sessions with a psychologist at 10 ignores the clinical judgement of psychologists and the choice of the individual about whether they need more treatment for their mental health condition.
- The proposed changes seem to suggest that when a person reveals to their psychologist that they have a more complex or serious problem than was originally anticipated, they will need to get another referral from the GP to a different psychologist under a different program (ATAPS) to start again. It is difficult enough for a person in a fragile psychological state to reveal their problems in the first place, let alone making them start again with a different psychologist. Quite aside from how frustrating this will be for consumers, there are therapeutic implications here that may see many people simply give up.
- The new system creates more obstacles and red-tape for mental health consumers. This will obstruct people from seeing the psychologist they want to see and require more paperwork and appointments.

In summary, I urge the Senate review committee to reconsider this proposed measure of arbitrarily reducing the cap for the permissible number of Better Access sessions, without an adequate rationale. Those patients with moderate to severe disorders are going to require more than 10 sessions in many, if not most cases, in order to achieve a sustainable treatment benefit. **The proposed changes to session**

caps is a retrograde step for those mental health patients who most need the additional sessions. I do not think this step should proceed, as there is no evidence that GPs or Psychologists are over-using available sessions under the current system.

Issue 2) Review of the two-tiered Medicare rebate system for psychologists, and workforce qualification and training of psychologists

My understanding is that the two-tiered system was put in place in acknowledgement of two different levels of training among psychologists in Australia. There are two main categories of psychologists in Australia:

- (1) Registered 4 year trained Psychologists (known recently as generalist psychologists) who hold a 4 year degree qualification with an additional period of supervised practice (varying from 1 to 2 years, now 2 years is mandatory) allowing them to practise as fully registered psychologists. Prior to completing supervised practice, psychologists may only be provisionally registered as psychologist registrars, practising under supervision, and not eligible for Medicare rebates.
- (2) Registered 6 year trained Psychologists, with a Masters degree, who usually complete a further 1-2 years of supervised practice. These Master of Psychology degrees are in a specialty area of psychological practice, including clinical psychology, counselling psychology, educational and developmental psychology, forensic psychology, community psychology, organisational psychology, health psychology, and sport and exercise psychology. Masters level or doctorate level academic training is increasingly accepted as the minimum entry level standard for psychologists to the workforce in western developed countries.

In recognition of the superior advanced level of qualification of those psychologists with Masters degrees plus supervision, the two-tier system was introduced for Medicare rebates under Better Access.

There are some anomalies with this however, as a clinical psychology masters degree was deemed to be the only suitable masters level pathway to the higher rebate. This meant that other equally highly qualified masters level psychologists in other specialty areas were not deemed equivalent. This was considered very contentious by masters degree qualified Counselling Psychologists, whose expertise in mental health and level of sophisticated, advanced evidence-based masters degree training is arguably equivalent to that of Clinical Psychologists.

Many other specialist psychologists, eg. Forensic psychologists, health psychologists, community psychologists, and educational and developmental psychologists have also argued that they deal with many community mental health presentations and issues in their private practices. They too have done the same masters degree level advanced academic training as have clinical psychologists, but specialise in a subset of mental health work.

In the initial period of Better Access, there was provision for Counselling Psychologists and others with advanced level training and experience in mental health to demonstrate their equivalent knowledge, supervision and professional experience in clinical mental health, sometimes via additional bridging courses or supervision, and thereby obtain recognition as 'clinical psychologists' for purposes of Medicare rebates. However, this pathway to the higher rebate has now been closed, so that ONLY those with clinical psychology masters degrees will be eligible for the higher rebate in the future.

It is argued by some 4 year trained psychologists, especially those with many years' experience, that they are unfairly discriminated against in the marketplace in that their Medicare clients may only receive a lower rebate, making it difficult for such psychologists to charge the same rates as their clinical counterparts and still remain competitive in private practice.

To my mind, it does seem important to recognise the significant additional advanced level training a masters degree provides, in comparison with the base level broader generalist

training of most 4 year psychology degrees in Australia. This comparison provides the basis for creating a distinction, and discriminating between the two training levels when setting the two tiers of scheduled fee and associated rebate levels. I would like to see this system continue, but provide for the automatic inclusion of counselling psychology masters degrees, along with clinical psychology masters degrees, as a directly relevant pathway to the higher tier status under Medicare Better Access. In private practice, counselling psychologists see exactly the same range of clients as their clinical psychologist colleagues, and do offer an equivalent level of expertise. Certainly in WA, for many years the checklist of clinical skills required for specialist title registration of clinical psychologists (following their initial 2 years of supervised practice) is almost identical to the checklist required for counselling psychologists.

If the parity between counselling and clinical psychologists under Medicare is not recognised, I believe the future of counselling psychology masters programs will be jeopardised, and the in-depth focus on counselling and psychotherapy skill development these programs offer, together with clinical assessment, formulation and treatment, may be lost in the future. The field of psychology would be the poorer if Counselling Masters programs had to close due to lack of demand, because of the privileged position of the very similar clinical masters programs. As for some of the other specialty areas, I think the most equitable approach would be to allow some possibility for bridging mechanisms for those masters graduates in private practice, who offer advanced level clinical skills to their subset of clients. After all, every psychologist who has completed a masters program has undertaken an equivalent level of academic study, and as such where the masters is relevant to clinical practice, should **not** be classified the same as a 4 year trained 'generalist psychologist'.

To deny any masters level trained psychologist the opportunity to achieve the higher tier rebate does seem discriminatory, especially where there is a demonstrable body of knowledge and skill in mental health treatment and service delivery. At least in the case of the 4 year trained psychologist, there is the option to go ahead and complete a masters degree. However, for those who already hold a masters degree with 6 years of training plus 2 years of supervised practice (eg. 8 year trained Counselling psychologists in WA), to be required to go back and do a further 2 years of masters study in clinical psychology and 1 year of supervised practice in order to achieve the higher tier rebate seems very unreasonable. This would result in 10 or 11 years of training [$6 + (2 \text{ or } 1) + 2 + 1$] to be deemed equivalent to a registered endorsed clinical psychologist (who is now only required to have 7 years of training, $6 + 1$)!

In terms of workforce options for psychologists, there are clearly many 4 year trained psychologists offering qualified, quality professional services, and this level of psychologist will be present for some decades to come, despite the push for a new minimum of 5 or 6 years of academic preparation before supervised practice. To provide for the evident community need for psychological services, it will be appropriate and necessary to include all psychologists in the ongoing Medicare Better Access provisions. However, I do believe it is appropriate that more highly qualified psychologists be able to access higher remuneration levels via the Medicare system, just as specialist physicians attract higher scheduled fees than general practitioners, based on their higher level specialist training and skills.

I have endeavoured to provide a balanced and informed appraisal of how best to deal with the two-tiered fee schedule and rebate system for psychologists, as it is not a simple issue to address, and must take into account a range of considerations. These include public access to services, differentiation between levels of academic training for clinical practice, parity between masters level graduates in different specialty areas, and the thorny issue of what to do with masters graduates in organisational psychology who find themselves also practising in clinical settings, but perhaps without the depth of clinical theory and skills training their counterparts would have received in Masters programs of clinical psychology, counselling psychology, educational & developmental psychology, forensic psychology and health psychology.

In conclusion, I am concerned about some of the proposed changes to the Better Access Program. My submission to the above Inquiry, makes the following recommendations concerning the 2 main issues covered above:

1) Proposed Reduction in Number of Sessions

Recommendation: Retain the current 12 session cap for standard presentations, allowing 18 sessions for exceptional circumstances. Do NOT jeopardise a well-functioning Better Access Program by risking a reduction in sessions, because the outcomes will be greatly compromised for a significant group of patients who most need the extra sessions.

2) Review of the two-tiered Medicare rebate system for Psychologists

Recommendation: Retain the two-tiered system. Give higher tier recognition to Masters trained psychologists in counselling psychology in parity with clinical psychology masters graduates, and continue to allow bridging programs for graduates of other masters' specialties who can demonstrate the clinical relevance of their masters level training.

Yours sincerely

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PBA Endorsements: Clinical Psychology & Counselling Psychology

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