5 August 2011

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

The Community Affairs References Committee,
Re: Senate Community Affairs Reference Committee inquiry into Commonwealth Funding and Administration of Mental Health Services

**Background**

I thank the senate for considering these matters.

I am an endorsed clinical and counselling psychologist.
I hold a position as Principal Clinical Psychologist at a major teaching hospital (part-time) and I have a part-time private practice in clinical psychology.
Currently I am a board member of major primary health care agency, and a long-standing judge in Victorian State Public Health Awards.
Previously I was Foundation Director of a university research centre in primary health care and sat on government, health department and peak health industry bodies and committees. I have had many years experience teaching undergraduate and postgraduate university courses in health sciences.

I would like to comment on the following:

> **(iv) 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;**

I do not support the reduction in sessions from 12 to 10, and the removal of the provision for an additional six sessions in 'exceptional circumstances.' I believe that these measures will be detrimental to clinical outcomes for patients.

Some patients with some conditions will be able to be successfully treated in 10 sessions. However, the standard is that 16 – 25 sessions are required for the provision of evidence-based therapy. The more complex the patient, the more difficult the person's situation and the more severe the disorder, the greater is the need for more sessions.

The removal of the additional six sessions for those in exceptional circumstances is particularly unhelpful. Access to these additional sessions is not easy: two practitioners, a psychologist and a general practitioner both need to assess the patient and be convinced that the additional services are required. Even restricting the additional 'exceptional circumstances' sessions to clinical psychologists would be preferable to their wholesale removal.

**(e) mental health workforce issues, including:**
**(i) the two-tiered Medicare rebate system for psychologists**

I thought that my experience might help shed some light on considerations of the two-tiered system. I completed my four year honours degree in psychology in 1974 and considered my career options. One path was to take a paid job as a psychology officer and undertake two years supervision in psychology so that I could be registered. The other was to complete a two year full-time masters course in Clinical Psychology. I took the advice of Mr David Ross the then Chief Psychologist in Victoria that the post-graduate training course was notably superior the '4 + 2' option and applied for the postgraduate program. To this day I remain very pleased about this choice. Selection was thorough being based on academic marks and clinical aptitude, as determined by interview and referees reports. My application was successful and I was one of the seven chosen for the course, which had an intake every two years. Like most of the others I did not complete all the work in the minimum two years and it took me the equivalent of about two and a half years full-time to successfully complete the program. Subjects included clinical assessment undertaken by interviewing patients with a variety of psychiatric disorders at a psychiatric unit, and considerable supervised work. Assessment was by written examinations, clinical exams, and written assignments. It was a demanding course and provided a solid preparation for work as a clinical psychologist.

It is my experience that only post-graduate clinical psychology programs provide extensive training in clinical diagnosis. I do not believe that it is at all common that non-endorsed psychologists have extensive training in this area – and it is certainly not provided in undergraduate courses. (I have taught undergraduate psychopathology subjects.) While I am very sympathetic to the claims of endorsed counselling psychologists who also have high quality post-graduate training, I think that expertise in psychiatric diagnosis is not at the same level as with clinical psychologists. This situation could be addressed by supplementary training.

I also support the current two-tiered system from my experience in working in public psychiatry, e.g.

- The area mental health service in which I work has only ever employed clinical psychologists.
- In my unit we occasionally receive referrals from GPs where a patient's treating psychologist has requested a psychiatric assessment. I have been surprised as some of these have been relatively straightforward to determine (for a clinical psychologist). None of these referrals have come from clinical psychologists; all have come from generally registered psychologists.
- Similarly from my unit (and my understanding of the area mental health service more generally) referrals for discharged patients are only made to clinical psychologists (and very occasionally to counselling psychologists).

In addition, it is my understanding that all psychologists can apply for endorsement in clinical psychology and provide evidence of their training and skills. Further if their application is not successful then further training can be undertaken to meet the requirements.

I would not support a reduction in the level of Medicare rebate for clinical psychologists. In my practice I see a maximum of six patients per day, often see people for more than an hour, and bulk bill many. This is done to provide a high quality service. A reduction in the rebate would require me to severely curtail what I do and may well make my practice unviable. I enjoy what I do and believe that I provide a high quality service

**(j) any other related matter**

Some thought could be given as to whether it is ideal to encourage individual private practice as soon as one qualifies as a psychologist. There could be benefit in requiring newly qualified psychologists to work in public settings such as hospitals or schools for two years before being registered to provide Medicare-supported services in private practice. I understand that medical graduates cannot work privately and provide Medicare-supported services immediately upon graduation.