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

4th August 2011

Dear Sir/Madam,

I am a clinical psychologist. I achieved this specialist qualification by completing a postgraduate course in clinical psychology, and receiving the subsequent necessary supervision and professional development for endorsement. I am a full member of the Australian Psychological Society, and member of the Clinical College, and am recognised by the Psychology Board of Australia as having specialist endorsement. For all these reasons I am registered as a specialist Medicare provider for clinical psychology services under the Better Access to Mental Health Medicare Scheme.

I have invested significant personal time and money in developing my skills to provide mental health services – as anyone who has registered as a psychologist must have also done so. I greatly value the Government's commitment to improving access and outcomes in Australian mental health services. I still feel fortunate about the opportunities that Better Access has given us as a profession and for Australian consumers. Your review highlights the significant importance of this scheme when 1 in 19 Australians have been provided with a mental health treatment plan. Unfortunately, the scheme has stirred some division within our profession. I think it is important to point out that many of these issues existed prior to Better Access – psychologists who are college members versus those who are not, the push to faze out the undergraduate model of psychologist training, and the argument around experience versus qualification. The task of this senate inquiry should not be to settle a debate within our profession. The task should be to allow the Better Access scheme to support people with mental health concerns and fund the most qualified professionals to do so. In addition there clearly seems to be a need to recover some of the funding to the Better Access scheme to help support some of the new initiatives. Like my colleagues, I would like to make a few points for consideration.

(b) changes to the Better Access Initiative, including:
(ii) the rationalisation of allied health treatment sessions,

The reviews seem to indicate, and my practice data would also support, that the large majority of people seeking services under a mental health treatment plan receive less than 10 sessions. However, the small number of people who do attend beyond this would be significantly disadvantaged if they were no longer supported by this scheme.

For example, recently I saw a teenage client during her completion of grade 12. Her final weeks of school occurred between our 10th and 12th session. If she had not been able to attend during this time I strongly believe she would not have obtained an OP, may have been readmitted to hospital for suicidal ideation, and suffered significant ongoing stress. Fortunately she was able to continue to be supported by Medicare, she obtained an OP, significantly improved in her mood, is no longer having thoughts of suicide, and is about to commence university.

Another example is a young women I saw who after her 10th session was the victim of a violent crime and subsequent court process. This obviously complicated her already existing depression and anxiety. Without the support of those extra Medicare sessions I believe she would not have attended therapy and may have been more likely to develop a severe and more impairing problem.

I could list many others whose lack of access after their 10th session would have significantly changed their short and long term outcomes, and potentially increased their likelihood of burden on the mental health system in some other way. It is true that they are the minority – and if that is the case surely the relatively minimal gain from reducing the number of sessions to 10 from 12 is outweighed by the significant importance of those few sessions to the individual.

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

Whilst I openly recognise that there are many experienced and exceptional generally registered psychologists (who may be members of other specialist colleges, and who may have postgraduate qualifications), like my clinical psychologist colleagues, I support the maintenance of the two-tiered fee structure.

For years prior to the Better Access scheme The Australian Psychological Society and University institutions were vocal about removing the 4+2 process for registration as a psychologist. There was a strong push to obtain postgraduate qualifications to increase our standing as specialists and to closer meet the US and UK standard qualification for psychologists (I believe some of the previous submissions have successfully summarized this comparison with overseas standards). Psychology is divided into many specialties, however, clinical psychologists are especially trained in the diagnosis and treatment of mental health disorders. If we are to maintain and strive towards a more globally recognised standard in clinical psychology we must begin to recognise those who have received those qualifications, including financial recognition.

During the initial years of the Better Access program, prior to the introduction of the national registration board, it was possible to apply to the clinical college for membership by demonstrating expertise and experience equal to (and beyond) the requirements of the college without the completion of a clinical postgraduate

course. Generally registered psychologists, particularly those with other psychology postgraduate qualifications and/or many years of experience, who believed their skills were of a high standard had the option to apply to the college and therefore have their skills recognised though the two-tiered Medicare structure. Some people successfully did this. Others spent significant personal time and money returning to complete a postgraduate degree or received the required extra supervision and professional development so that they could be recognisied as a specialist clinical psychology provider. I would hope that the Government would not devalue the effort of these individuals and clinical psychology providers as a whole, by removing the two-tiered system.

I can certainly understand the internal debate that this has created amongst the psychology profession as the majority of providers are not clinical psychologists. However, I ask the Government to recognise that there has similarly been a two-tiered approach based on qualification within the medical profession for years. Different rebates are offered to doctors based on a specialist nature. We and the Government pay more money for a fully qualified specialist cardiologist admitted to the college after significant time, training, and assessment, than a general medical doctor. It is true that they have both done the same undergraduate course, and are both called doctors, may be of equal age, and may both know a far bit about cardiology, but one of them has invested in the extra level of training and qualification. Therefore, we as consumers accept that we pay them more, and the Medicare system has reflected this. If all doctors received the same scheduled fee with no recognition of qualification surely the incentive to expend the amount of time and money required to become a specialist would be reduced and we would be significantly lacking in specialist expertise.

In addition, the model of higher financial compensation for higher qualifications has gained significant grounds in the State Government hospital system (at least here in Queensland). In general, psychologists with postgraduate qualifications employed by QLD Health receive higher award rates than predominantly undergraduate trained psychologists. For exactly the reasons we have been expressing to you in our submissions. Surely psychologists in the Medicare funded private sector are entitled to this recognition as well.

Statistical information collated from DoHA consistently showed that clinical psychologists have a lower co-payment than general registered psychologists (with the only exception being remote locations). If the two-tiered model was abandoned and the rebate provided to clinical psychologists reduced this co-payment will increase, disadvantaging many people using clinical psychologist services. More importantly the portion of clinical psychologists who engage in bulk-billing will be reduced or cease to exist. This will increase the burden and cost of public mental health services.

Clinical psychologists are significantly less in number as providers under Better Access, and consequently have vastly less sessions claimed through them. Surely the gains from the reduction of the clinical psychology rebate and scheduled fee would be minimal. I hope the Senate can see that the valid reasons raised by many of the clinical psychologists in their submissions give value to the extra cost incurred by supporting the two-tiered structure.

I also think it's important to mention that the rate of increase of clinical psychologist providers seems to have reduced over the last few years and reached more of a plateau than the general psychologists (when reviewing DoHA's statistical data). I would think this is because it can only increase at the rate that the universities can produce eligible clinical postgraduate students. It would be wise to support and encourage the incentive to obtain postgraduate qualifications, otherwise if the incentive is removed the Government may find an even sharper increase in generally registered Medicare providers claiming services. Surely as a potential long-term effect this would detract from the short-term gain of reducing clinical psychology rebates.

Recommendations for consideration
(including possible options for recovering money from the Better Access scheme) –

- Retain the current two-tiered fee structure as a reflection of the additional qualifications psychologists are required to obtain to call themselves clinical psychologists.
- Remove the requirement for GPs to complete a mental health plan, instead substituting it for a simple letter of referral, in line with other specialist referrals. I believe this would alleviate some of the significant pressure and time consuming nature the Better Access program has created for GPs.
- Consider the initial goals of the Better Access scheme and the structure of two-tiers. For registered psychologists to provide Focused CBT Psychological Strategies, and for more complex clients requiring these and varied psychological therapy to be referred to a clinical psychologist.
- For this reason consider the generally registered psychologist services be reduced to 6 +4 sessions of Focused CBT Psychological Strategies, and clinical psychologist providers to be eligible for the current 6 +6 (+6 in exceptional circumstances) as specialists in complex psychological therapy.
- Consider the removal of social workers, and occupational therapists as providers.

I thank you for the time you have taken to review this submission and am willing to be contacted regarding any of the comments. As much as I am content to provide my personal details to the Senate, I have chosen to withhold them from my submission due to the risk of personal and professional repercussion.
Yours sincerely,
A clinical psychology provider.