

Submission to Senate Community Affairs Reference Committee Inquiry into Commonwealth Funding and Administration of Mental Health Services.

4 August 2011

From:

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Member, College of Educational and Developmental Psychologists, Australian Psychological Society.
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Member, EMDRAA (EMDR Association of Australia).
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Re: Terms of reference:

(b) changes to the Better Access Initiative, including:

- (i) the rationalisation of general practitioner (GP) mental health services,
- (ii) the rationalisation of allied health treatment sessions,
- (iii) the impact of changes to the Medicare rebates and the two-tiered rebate structure for clinical assessment and preparation of a care plan by GPs, and
- (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;

(c) the impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program;

(d) services available for people with severe mental illness and the coordination of those services;

(e) mental health workforce issues, including:

- (i) the two-tiered Medicare rebate system for psychologists,
- (ii) workforce qualifications and training of psychologists

My submission is to urge for:

(i) The discontinuation of the two tier system of medicare rebates

I have read with disgust and dismay the ill-informed opinions expressed in many submissions in which individual psychologists suggest that there is a disparity in the service offered to clients of Generalist Psychologists and the (allegedly superior) service offered by those holding "Clinical" endorsement, they also display ignorance of the actual training given to psychologists registered under the "4 + 2" – meaning 4 years of university study followed by a minimum of 2 years of full-time supervised practice.

I do not hold "Clinical" endorsement, however, I would make the following points for your consideration:

- a) As a registered Supervising Psychologist who has been responsible for the mentoring and training of many psychologists now registered after completing the "4 + 2" pathway to registration, I would urge members of the committee to familiarise themselves with the range of competencies that must be adequately addressed – and must be shown to be addressed – by those achieving registration by this route.

This most comprehensive training decrees that where a supervisor cannot themselves provide training in the full range of, the provisional psychologist must be trained by one or several "Secondary supervisors" approved by the Board. The Board decrees the extent of training and manages and evaluates the satisfactory completion of such training. If not satisfied, the applicant for registration may be asked to complete further supervised practice – the so-called 4 + 2 becomes 4 + 3 or even more to ensure full competency.

- b) In my private practice as sole practitioner and sometimes as co-therapist with psychiatrists, general practitioners, paediatricians or other allied health professionals, I have treated many hundreds of clients, children, adolescents, adults of all ages. Presenting conditions have included Schizophrenia, Bipolar disorder (1 &2) Personality Disorders, Depression, various Anxiety and Anxiety-related disorders, Grief, Acquired Brain Injury, Social Phobia, Learning Disabilities,

PTSD, Victims of bullying, Victims of Crime, Workcover and Traffic accident victims, Attention Deficit Hyperactivity Disorder, Sleep disturbances, Eating disorders and Anger management issues, to name a few. I am confident that these clients received psychological interventions of the highest order – attested to by their word-of-mouth referrals of friends and family. I am equally confident that my colleagues in private practice are providing a similar service.

- c) Along with thousands of other psychologists, indeed as demanded by the APS professional development program, I have maintained a high level of ongoing education and training having, myself, been certificated in Cognitive Behavioural Therapy, Rational Emotive Behavioural Therapy, Eye-movement Desensitisation reprocessing (EMDR) levels 1 and 2 and Emotion Focussed Therapy.
- d) Having lectured in the M.Psych (Educational and Developmental), in the M.Psych. (Counselling) and in the Postgraduate Diploma in Psychology at University in each of the past four years, I have witnessed the rigour and comprehensiveness of the training in the masters degrees, including all of the clinical, assessment and psychotherapeutic aspects as required for accreditation. These courses certainly prepare, to the highest level, students for their careers as “Scientist practitioners”. I am certain that other accredited masters level courses prepare new practitioners to the same standard – otherwise they would lose their accreditation!
- e) Some of the provisional psychologists that I have supervised for registration have gained “Clinical” endorsement – one that I am aware of – and I am sure this is not an isolated case - does not have any masters’ degree. There seems to be inconsistency in the way that endorsement has been accredited.

(ii) The annual number of rebated sessions to be retained (or indeed extended)

- a) All psychologists are ethically bound to avoid over-servicing clients. This is the first safe-guard for government financing.
- b) Best-practice indicates that the minimum necessary number of consultations required to address the client’s needs should limit the length of treatment, however:
 - 1. maintenance when a condition has been stabilised may require ongoing, less frequent, consultations. This may require more than the proposed 10.
 - 2. Best practice indicates that for some conditions, 26 to 30 consultations (i.e. over the period of six months, weekly, or one year, fortnightly, is optimal.
- c) Since the inception of medicare rebates, the more needy members of the community have been able to obtain psychological services. This certainly did not occur previously, I have many clients with health-care cards or straitened circumstances whom I either bulk-bill, or charge the amount that they will be rebated, so their consultation with me is cost-free (they go straight to Medicare from the consultation), these are often those who need more extensive treatment, requiring 12 or 18 consultations per year and/or group consultations as well. They do not have “Extras” or hospital cover so cannot possibly afford to extend their treatment to the optimal number of consultations.
- d) I note from the statistics provided by Medicare that the majority of intervention programs last for fewer than the 18 maximum and often fewer than the 12 regularly available. I believe that the reduction to 10 consultations will result in little real savings but will disadvantage those in most need.