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Dear Committee Members,

In writing to the Government's enquiry into the funding and administration of mental health services in Australia I wish to comment on:

- (b) changes to the Better Access Initiative, including:
 - (ii) the rationalisation of allied health treatment sessions,
 - (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;
- (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, and
 - (iii) workforce shortages;

In writing this submission I draw on my knowledge and experience as a senior clinical psychologist in a public mental health service, as the head of psychology for this mental health service, as a conjoint senior lecturer in a school of psychology at a regional university & as an honorary associate to a metropolitan university, as a psychotherapy educator for a psychiatry training program and as a registered clinical psychology service provider under Medicare.

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

Public mental health services primarily focus on 'severe' mental illness. Patients of these services are, however, not static in their mental health. The same individual may at different times be conceptualised as in remission, mild, moderate or severe. For some people, being on the border, or moving between moderate & severe can be extremely unsettling & a change in treating professionals potentially magnifies matters. The current model of 6+6 sessions with

another 6 under exceptional circumstances permits a continuity of care when most needed. For the individual concerned being able to continue seeing their treating therapist may make the difference between being cared for in the community & a requirement to be admitted to an acute mental health facility. In general, mental health acts in Australia support the provision of a less restrictive model of care. For some individuals the reduction of available sessions will place them at increased risk of requiring care in a more restrictive environment at greater cost to the community, not to mention, the impact this will have on them & their family. This will be particularly true in rural locations.

I would encourage the committee to consider means of continuing the current treatment model for those identified as being most at need.

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

In general, the provision of services to people with severe mental illnesses is done by public mental health services with links to treating GPs, private psychiatrists & psychologists and NGOs. While there are a number of private health systems providing services for those with severe mental illnesses they are invariably transferred to the public system when the risk becomes too great. While there has been & there are plans for further increases in mental health funding the proportion that has allocated to public mental health has been minimal. This minimal increase in funding and changing patterns of service provision have seen a decrease in accessibility of services to those with mental health problems & their families.

I would encourage the committee to consider ways of increasing the community's access to responsive community-based public mental health services to minimise the impact of illness on individuals and their families. Doing so will maximise the likelihood of care continuing in the community and minimise the need for admissions to acute inpatient units.

(e) mental health workforce issues, including:

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

The training of registered psychologists in Australia takes one of 2 paths. All psychologists undertake a minimum of 4 years of study. Unlike other health professionals these first 4 years do not include training. The training component of psychology occurs in a post graduate context. This is a function of student numbers. At the university at which I teach there were approximately 900 first year students and 20 post graduate clinical psychology positions. The majority of students undertaking early psychology studies have no intention of becoming psychologists but value the study of psychology in the context of other career aspirations.

Just as psychiatry is the mental health speciality of medicine, clinical psychology is the mental health speciality of psychology. Those undertaking the study of clinical psychology undertake another 2 (masters programs) or 3 (professional doctorate programs) years of study and clinical placements with a focus on the assessment, diagnosis & treatment of mental health conditions. The period of registrarship which follows the completion of post graduate studies extends the minimum period of training to become an endorsed clinical psychologist to 8 years. This is second in intensity & breadth to the training provided for psychiatrists. Apart from those psychiatrists who chose to specialise in psychotherapy as part of their senior

training clinical psychologists are the most highly trained providers of non-medical interventions for the mental health conditions. Psychological interventions, either in conjunction with medical management for many conditions, or alone, have a significant impact on the quality of the lives of those who experience, directly or indirectly, the impact of mental illness.

The other pathway to becoming a registered psychologist involves a minimum 2 year internship. The quality of this internship will be dependent on the learning opportunities available and the experience of the supervisor. The vast majority of these occur outside public mental settings. Unlike early career doctors who are required to spend a number of years increasing their knowledge & skills in major teaching hospitals psychologists are not required to undertake a similar pathway.

While there are many good & experienced psychologists, it is reasonable to expect that a more highly trained clinical psychologist would provide as a minimum the same, if not better quality of service, than their lesser trained colleagues. In recent years I've had two basal cell carcinomas removed, one on my face by a surgeon & one on my hand by a GP specialising in skin cancer. Both provided high quality care. Despite the competence of both practitioners, the medical system, health insurance companies and Medicare recognise the differential in training and the experience that comes with this training in terms of remuneration. While remuneration is only one of many incentives for undertaking further learning and specialisation, it is an important driver in this process – a process that increase the quality of health care provided to Australians. The same is true for those considering undertaking post graduate training in psychology. A professional clinical doctorate costs in excess of \$100,000 when course fees and loss of income to attend lectures and clinical placements is taken into account. This is a significant disincentive to those early in their careers.

In many similar countries a minimum of 6 years of study is required to become a psychologist. Australia could expect to provide a similar level of training and expertise for psychology with attendant increases in quality and efficiency of services by approximately doubling post graduate clinical psychology training positions in Australia (based on Workforce Australia figures). The creation of training positions linked to this in our major health services, similar to that of medicine and as practiced in the UK, would further increase the quality of mental health services provided to Australians with mental health conditions.

The provision of high quality mental health psychology services in public mental health requires the employment of appropriately educated, trained and supported clinical psychologists. This is particularly difficult in rural, and to a lesser degree, regional areas. Changes that decrease the likelihood of people undertaking clinical psychology studies will only worsen this.

The introduction of Medicare funding for the provision of psychological services has been a huge step in helping many Australians who could not otherwise access/afford mental health services to access these services. It is important to maintain these gains in mental health services.

Thank you for your consideration of the matters raised above.