Submission to Senate Inquiry into Commonwealth Funding and Administration of Mental Health Services

I am providing comments from the point-of-view of a psychology profession director in a large public sector health service. I am not registered to receive Medicare rebates and therefore have no direct personal interest in the issues under consideration.

My basic contention is that the cut in maximum Medicare sessions for psychology plus a removal of the higher rebate for clinical psychology would increase pressure on the public mental health system and compromise our supply of clinical psychologists. We need more clinical psychologists.

I address the following points from the Terms of Reference:-

(b) (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

Patients with more severe (including moderate) mental illness may require more than the maximum psychologist sessions available under Medicare. As a result Medicare will often pick up the bill for 6, 12 or more sessions (up to 10 under the planned changes) which will ultimately be ineffective. The patient may then seek a service in the public mental health system where a longer course of treatment may be available, or, they may seek treatment from a psychiatrist who does not have the session limits that psychologists have. Treatment may start again with significant waste to the health budget overall. Thus, a reduction in the maximum number of sessions to 10 may lead to greater inefficiencies with a higher rate of incompletely treated patients seeking other sources of publicly funded care. That has the potential to further stretch our limited public mental health psychology resources.

It would make sense to retain the availability of more extended treatment (up to 18 sessions or more) with a clinical psychologist who, by virtue of their specialist training, is equipped to deal with the more severe mental health conditions. (The more severe conditions are those at the more severe end of the mild to moderate continuum plus conditions which are intrinsically severe which inevitably enter into the range of conditions referred to clinical psychologists under Better Access.)

It is important to bare in mind that psychiatrists often provide identical psychotherapeutic interventions to psychologists but without the session limits and at potentially significantly greater cost to the health budget.

(e) (i) The two tiered Medicare rebate system for psychologists

This rebate system recognises the additional training which clinical psychologists have (6-7 years of university training including supervised practiced) compared with psychologists (4 years of university training and 2 years of supervised practice – the so-called “4+2” option).

Clinical Psychology is the only profession, apart from Psychiatry, whose entire accredited and integrated postgraduate training is specifically in the field of advanced evidence-based psychopathology, assessment, diagnosis, case formulation, psychotherapy, evaluation and research across the full range of severity and complexity in mental health. Clinical psychologists are well represented amongst the innovators of evidence-based therapies,

NH&MRC Panels, other mental health research bodies and within mental health clinical leadership positions. For these reasons clinical psychologists are critical to the delivery of efficient, quality mental health services in the public sector.

Our experience in the Health Service in which I work is that clinical psychologists bring a more predictable set of clinical skills, a stronger grounding in theory, a greater awareness of and commitment to evidence-based practice, a more thorough training in diagnosis, a more critical and self-reflective approach to practice and greater efficiency in service provision. This is a product of the centralised quality control in the university-based clinical psychology training programs. The supervised practice system does not deliver the same consistency or intensity in the development of knowledge base or clinical skills in those with 4+2 training. Clinical psychologists cost us more but we preferentially employ clinical psychologists because we get better value for money.

What has this to do with the two-tiered rebate system? Removal of a two-tiered rebate system would remove a significant incentive for would-be psychologists to undergo clinical psychology training which they do at significant personal expense (university fees and income foregone of up to $200,000 or more). A decline in the supply of clinical psychologists would have major negative consequences for our health system, particularly the mental health sector. Australians would suffer as a result.

(e)(ii) workforce qualifications and training of psychologists

Many western countries (e.g. UK, USA, NZ, Canada, South Africa, various European countries) require at least a Masters degree as a pre-requisite for registration and practice as a psychologist. Australia is more or less alone in allowing those with only undergraduate psychology degrees to practice (independently) as psychologists. In Australia our training of clinical psychologists at Masters and Doctoral level is comparable to minimum standards in other countries. Many 4+2 psychologists would elect to undertake higher levels of training if training places were available. Currently, training paces are limited by the limited funding available to universities who often run these courses at a loss. Recent research has shown that if we could double the number of post-graduate training places we could meet the demand for (clinical) psychologists without needing to resort to the 4+2 option.

Our experience suggests that this would deliver a significant improvement in the quality of services provided in mental health and, by virtue of greater efficiency, a decrease in occasions of service per client and, therefore, greater service availability for a greater number of patients. The more highly trained clinical psychologists would get better results and generally get them more quickly than a 4+2 psychologist. But the bottom-line is that a minimum of 6 years of university training, as recognised elsewhere in the developed world, is necessary to train a competent clinical psychologist.

(e)(iii) workforce shortages

In the Health Service in which I work we have difficulty filling psychologist positions with clinical psychologists and this is a particular problem in rural areas. An increase in funding to universities for the training of clinical psychologists would improve supply generally and also redress some of the metropolitan regional/rural/remote imbalance in supply of clinical psychologists.

By its nature, training of clinical psychologists is a resource intensive process with student numbers in courses often below that which universities consider economical. Therefore, a significant injection of additional funding would be required to enable universities to expand training opportunities and increase the supply of clinical psychologists.

In addition to the clinical psychology specialty, there is also an under-supply of clinical neuropsychologists. The majority of clinical neuropsychologists are trained in Victorian universities (three programs) with a resultant imbalance in supply across the rest of Australia. (NSW, Qld and WA have one program each.) Clinical neuropsychologists by virtue of their training in evaluation and treatment of brain dysfunction are becoming an increasingly important resource in aged care services, including specialist mental health services to the aging population, as the incidence of conditions such as dementia increases. In the Health Service in which I work we have extreme difficulty recruiting clinical neuropsychologists. Improving the supply of clinical neuropsychologists would require significant funding enhancements for universities prepared to establish training programs. A minimum addition would be establishment of an additional program in NSW. An expansion of such training would be a significant step in equipping our health workforce to deal with the health issues of our aging population.

Summary

1. A reversal of the decision to cut maximum Medicare funded sessions for psychologists, particularly clinical psychologists, could result in greater overall efficiency in funding of mental health services and reduce the strain on public sector psychology services.

2. The two-tiered psychology rebate reasonably recognises the higher level of training and service delivery efficiency of clinical psychologists. Removal of the higher rebate for clinical psychology will negatively impact on the availability of clinical psychologists and on Australia's capacity to deliver high quality mental health services.

3. Post-graduate university training of psychologists through Masters and Doctoral level study is the recognised international standard. The level of training and the supply of clinical psychologists should not be compromised by removal of the higher rebate for clinical psychology. It should be recognised and supported through enhanced funding to universities to provide additional training places for psychologists in specialties such as clinical psychology and clinical neuropsychology.

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