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To: **The Senate Community Affairs Reference Committee inquiry into Commonwealth Funding and Administration of Mental Health Services**

As a Clinical Psychologist with almost 20 years post-graduate experience working both in the private and public sectors I am writing to express by deepest concerns regarding two very important matters.

1) "The Senate Community Affairs Committee has concluded that there are no grounds for the two-tiered Medicare rebate system for psychologists and recommends the single lower rate for all psychologists including clinical psychologists....."

It would appear that the reference committee is unaware that there is good reason for the two tiered approach.

1.1) Higher level of qualifications of the tier 2 – Psychologists

The qualifications differentiating tier 1 from tier 2 has essentially meant that there are those with base grade qualifications who have less expertise than those in the second tier who have taken the extra effort and responsibility to further their education in order to get the essential qualifications deemed necessary to offer a specialist service in order to provide a higher, more efficient service of care to consumers.

Those who are in tier one, whose clients currently receive a lower rebate rate for their services have essentially completed in total 4 years of University which includes a basic three year University degree with an additional one year of either an Honours Degree or Diploma. They have then completed a further 2 years working under supervision.

This differs greatly from those who are in Tier 2. Those who are in this level are essentially Clinical Psychologist and have completed a minimum of 6 years of University training which includes a Masters degree in Clinical Psychology and a further 2 years of supervision adhering to the strict guidelines as set by the Australian Psychological Society's College of Clinical Psychologists. This essentially means 8 years of training rather than the base grade of 6 years.

In the last 12 months all Psychologists have needed to be registered by the **Australian Health Practitioner Regulation Agency (AHPRA).** Only those who have completed the rigorous training and have fulfilled the strict criteria as set by both AHPRA and the APS College of Clinical Psychologists are able to practice as Clinical Psychologists. The essential criteria to become a Clinical Psychologist include:

- An accredited Doctorate degree in clinical psychology followed by a minimum one year full-time equivalent supervised practice; OR
- An accredited Masters degree (or combined PhD/Masters) in clinical psychology, followed by a minimum of two years of supervised practice.

This requirement insures uniform standards of excellence in Clinical Psychology training throughout Australia. It is also consistent with the standards of Clinical Psychologists training in both the United Kingdom and the United States of America.

1.2) Tier 2 Psychologists have more training and are better able to offer appropriate and more scientifically rigorous treatment.

The nature of the work in Tier 1 is equivalent to "Basic" Psychology which includes activities such as establishing, maintaining and supporting relationships; and using of simple techniques (relaxation, counselling, stress management). It may also encompass undertaking circumscribed psychological activities (e.g. behavioural modification). These activities may be described by protocol.

The nature of the work of Tier 2 Psychologists is more complex as they are trained as Clinical Psychologists. Other than Psychiatry, Clinical Psychology is the only other mental health profession whose complete post-graduate training is in the area of mental health. Consequently, due to their theoretical, conceptual, empirical and applied competencies, Clinical Psychologists are specialists in the provision of psychological therapies.

They are trained as scientist-practitioners. This added emphasis on the scientific in university training enables the profession of Clinical Psychology to bring research and empiricism to human service delivery and thus increase accountability. The formal scientific training of Clinical Psychologists does not make research the end in itself, but is applied to the delivery of psychological services. Empirical training equips Clinical Psychologists with the skills to understand and contribute to new research, evaluate interventions and apply these empirical skills to the treatment of consumers.

As a result of their training, Clinical Psychologists have a thorough understanding of varied and complex psychological theories and have the ability to formulate and respond to both complex disorders and to novel problems, generating individually tailored interventions based on this solid knowledge base.

All Clinical Psychologists need to continue with their Professional Development in order to maintain the standards as set by the Australian Health Practitioner Regulation Agency. It is mandatory for Clinical Psychologists to both maintain and upgrade their skills by attending specialist seminars/workshops

1.3) Different rates of rebates related to speciality reflects level of expertise

Many other professions such as nursing, teaching, medicine also have different levels of training and expertise which is recognised and rewarded. Let us take as an example someone who has completed a basic medical degree and then continued on to further their training and become a cardiovascular specialist. Would it be reasonable to assume that the GP would have the same level of training as that of a Cardiovascular Specialist? Would the Senate suggest reducing the rebate a consumer receives from seeing a Cardiovascular Specialist should be decreased to the amount of that of a GP?

Should the Senate decrease the rebate consumers receive to that of the basic level, this would meant that there would be fewer consumers able to meet the expense of seeing a specialist Clinical Psychologist. Most of the referrals which I receive in Private Practice come from Consultant Psychiatrists who deem it essential that the consumers they refer are seen by a specialist Clinical Psychologist to get the treatment they need.

By reducing rebates that consumers receive would not only mean that they would possibly not get the level of care they need and would affect the level of income of the clinician. Those seeing a Tier 1 Psychologist receive a rebate of $80 per hour whilst those being seen by a specialist Clinical Psychologist receive a rebate of $119.80 per hour. Would it be fair or just to ask anyone to reduce their income by 1/3? This would have ramifications as Clinical Psychologists would not be able to sustain offering their services and consequently consumers would miss out.

1.4) Insufficient scientific rigour of the Medicare study.

There are assumptions from this study that Tier 1 and Tier 2 Psychologists provide the same expertise and treatment outcomes. There are; however, concerns regarding significant research methodological issues that diminish the credibility of the Medicare study. The study

did not determine nature, diagnosis, level of complexity of diagnoses; or level of severity. It did not have a valid criterion measure actually related to a range of diagnoses or complexity in order to assess pre and post intervention condition of clients. It did not take into account medication use by the consumer or out therapy adherence indicators. Nor did it identify the nature or type of psychological intervention actually provided; by type of psychologist.

In Summary:

- Those who have undertaken and paid for the extra years of training and supervision required to become a Clinical Psychologist offer expert clinical treatment, which only serves the consumer. It keeps the consumer safe, it enables accountability.

- Whilst I understand that there are those who offer a basic psychology service and the clients that they see should be accordingly rebated, it is unreasonable to ask those who seek a specialist who has undertaken and continues to undertake further specialist professional development to be rebated at a base level.

- Should the Senate choose to put both non-clinical psychologists and the clinical psychologists into one pile the risks are:
  1) the standard of expertise will decrease, therefore the standard of care will decrease and be worse than that offered in the UK or USA.
  2) there will be no reason to offer best treatment outcomes as only the minimum will required
  3) the universities will be affected as there will be no reason for students to continue with their studies, to improve their skills in order to become specialist clinicians

I urge the Senate to maintain the current 2 tiers of rebates; offering the higher rebate rate for specialist Clinical Psychologists who can continue to offer a specialist, effective service to consumers who require this higher level of expertise.

2) The reduction of Medicare rebated sessions under Better Access from 12 with a capping of 18 sessions under exceptional circumstances per calendar year to a maximum of 10 per calendar year.

2.1) Better Access has improved access to mental health care for consumers with mental health disorders.

Uptake of Better Access services has been high in absolute terms, even among relatively disadvantaged groups in the community. Better Access is not just for the treatment of who were already in receipt of care and/or who have relatively mild symptoms; it is reaching significant numbers of people who have not previously accessed mental health care.

2.2) Many of those with complex needs and with severe level of disorder have sought treatment and has not just those mild to moderate problems

It is not reasonable to assume that the only ones seeking therapy from a Psychologist experience disorders within the mild to moderate spectrum. Most of the referrals which come into my private practice come from Psychiatrists and those consumers often have complex concerns which require additional and intensive therapy rather than a reduction in therapy. It is these same consumers who are ineligible to access to the public mental health sector.

In my public work we have been offering an effective group skills programme which has been highly regarded and is seen as the evidence-based treatment to be used for those with Borderline Personality Disorder. We offer a 20 week Dialectic Behaviour therapy skills group; however, we are not able to offer the essential individual therapy component to most of the participants. They receive this from experienced Clinical Psychologists in private practice. Without this ongoing therapy these consumers would not get the treatment they need and would remain disfranchised.

New research conducted by Harnett, O'Donovan and Lambert (2010) shows that for 85% of people to show clinically significant change in symptom severity occurs following around 20 sessions of treatment. This research shows that with 10 sessions of treatment, around half of people will need more psychological care to improve. These figures match survey data from the Australian Psychological Society about the work of Clinical Psychologists in the *Better Access* scheme. Limiting the maximum length of treatment at 10 sessions is plainly unrealistic and will set many people up for failure in the system.

2.3) Success of treatment for those who have needed more than ten sessions

Since the Government announced the Budget cuts, the APS has undertaken a study of the nature and severity of disorders of the Better Access consumers who will actually be affected by these cuts. The APS research, conducted on a large sample of 9,900 people who received between 11 and 18 sessions of treatment from psychologists under the program last year, shows that these are overwhelmingly people with severe depression or anxiety disorders, including posttraumatic stress disorder.

The study demonstrates that 84% of these people had a moderate to severe, or severe, disorder at the commencement of treatment, with nearly half (43%) having additional complexities such as a second mental health disorder, personality disorder or drug and alcohol abuse.

"Of course, these people required more than 10 sessions of psychological treatment to achieve an effective outcome," said Professor Littlefield. "The research shows that by the end of their treatment only 3% remained severely affected, while for 43% of people their disorders were effectively reduced to either no symptoms or only a mild presentation. How can it be seen as a saving to cut funding for these people who are clearly receiving effective psychological treatment under the Better Access program?"

In Summary:

The idea of cutting back a successful programme will not benefit either the consumer or the community. It will essentially mean that people will miss out on adequate treatment resulting in likely relapse which will have detrimental affect on both their capacity to work and their health care this will ultimately cost the government more.

I urge you to reconsider these new proposals about the *Better Access* initiative and leave the length of treatment intact at 12-18 sessions.

Maria Chorney
Clinical Psychologist