28 July 2011

To the Senate Community Affairs Committee

I wish to put forward my comment on the matter of the Better Access Initiative and the proposed Government Budget 2011-2012 changes to psychology services.

The prominent concern is the reduction of Medicare funded consultations by psychologists from a maximum of 18 sessions per year to a maximum of 10 consultations per year.

My experience as a clinical psychologist has been in adult mental health and I have been employed since 1983, following the completion of a Master of Psychology (Clinical) qualification. I have worked in both the public mental health sector and in the private sector. There has always been a demand for private psychology services where patients were unable to attend a hospital setting or a mental health clinic to access psychological consultations and have therefore been required to fund these services via private means. The access to Medicare refunds has allowed provision of psychological services to many more patients who could otherwise not afford the services and have therefore not obtained the benefits of specialized treatments that are evidence-based, or have done so at a significant personal cost. Many have been prepared to make such a sacrifice due to the detrimental effect that mental illness has on quality of life.

As an experienced clinical psychologist with expertise working with patients who have severe mental health problems I am referred a range of presenting problems including psychosis, bipolar disorder, eating disorders, depression and anxiety disorders, all of which have evidence-based psychological treatments. The number of required consultations is rarely less than 11 in one series of treatment, particularly an initial treatment series. In my public sector work where there was no pre-arranged limit to the number of consultations, many patients were required to be seen at least 20 times within a 12-month period along with being case managed by another mental health professional. The pressure of course in the public sector was that at times it was not possible to be seen by a clinical psychologist. I have found in the private sector that the limit of up to 18 sessions per year has been workable even for patients who have required additional consultations because I have arranged follow-up contact free of charge on an occasional basis with the relatively smaller number of patients for whom this is required.
That the research conducted by the Australian Psychological Society was able to show that a large number of patients have received effective treatment within 12 sessions of psychological consultations is testament to the effectiveness of these treatments, not as some have purported that psychologists treat the “worried well”. That is a term used to denigrate the education, specialization and practice of clinical psychology and I have never experienced such a denigration by health professionals with whom I have worked in the public mental health sector or referring health professionals in the private sector. I

am also encouraged that adult mental health in the public sector will be supported by the government over the coming years with additional funding because these measures are necessary. A health model that provides enhanced services in both public and private sectors is the one to work towards and I am a health professional who has experience working concurrently in both settings for many years.

I would urge the Senate Inquiry to consider maintaining the current level of Medicare-refunded psychological consultations per annum at 18, since this has permitted an effective and adequate service to patients who need to use these services. Referral from general practitioners has also been central to access psychological services since G.P.'s have often been required to attend to psychological problems within the G.P. practice with the time restrictions and the limited expertise in evidence-based psychological treatments that is part of such a practice.

An additional point is that the clinical psychology qualification requires specific further education at the Masters or Doctoral level including theory and practice in treating psychopathology. As students in post-graduate clinical psychology training programs we are required to attend practicum placements in hospital and clinical settings that treat mental illness, hence making it a specialization specific to mental health. I have also had many years experience as a supervisor training clinical postgraduate students within hospital settings and am aware of the rigours of this training program. To qualify and practise as a senior clinical psychologist in the public sector it was mandatory to be a member of the Clinical College of the Australian Psychological Society and the reason for this standard of practise has to do with the level of specialization in the area of psychopathology.

In order to legally maintain endorsement for registration with the Psychology Board of Australia we are required to participate in specific Professional Development and supervision of our clinical work. This legal recognition is justified on the grounds that we are specialists in the practice of psychology and it requires many hours of additional work and study each year to accomplish and maintain this standard.

To summarize, I consider it a community imperative to maintain the maximum number of Medicare-funded psychology consultations at 18 per annum, to be available to members of the community in the private sector as well as to support the public sector practise of psychology, at the present time and into the future. The second point is maintaining recognition of clinical psychology as a specialization that is legally endorsed and a required minimum to administer treatments in both private and public mental health sectors.

I would be happy to support this submission with any further information that may be required.

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