

Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600
Australia

28th July, 2011

Dear Committee Secretary:

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

Clinical Psychology is one of nine equal specialisations within Psychology. These areas of specialisation are internationally recognised, enshrined within Australian legislation, and are the basis for all industrial awards. They have been recognised since Western Australia commenced its Specialist Title Registration in 1965, and it is the West Australian model which formed the basis for the 2010 National Registration and Accreditation Scheme recognition of specialised Areas of Endorsement. All specialisations require a minimum of eight years training including a further ACPAC accredited postgraduate training in the specialisation leading to an advanced body of psychological competency in that field. No specialisation should be referred to in a manner that creates the appearance of the same level of skill and knowledge as the basic APAC accredited four year training of a generalist psychologist. As is the case with Clinical Psychology currently, each area of specialisation deserves a specialist rebate with its own item number relating to that which is the specialist domain of that area of psychology (e.g. for clinical neuropsychology - neuroanatomy, neuropsychological disorders/assessment/rehabilitation, etc; for health - clinical health psychology, and health promotion; forensic - forensic mental health, etc). Specialist items for the other specialisations of psychology may mean that clinical psychologists might not qualify for any those second tier items pertaining to other specialisations; however, we deeply respect specialisations within psychology and believe that our members would seek to undertake further training in those fields should they wish to seek to demonstrate that they have attained those other advanced specialised competencies that are not part of clinical psychology.

Regarding our specialisation, we wish to re-state that Clinical Psychology requires a minimum of eight years' training and is the only profession, apart from Psychiatry, whose entire accredited and integrated postgraduate training is specifically in the field of lifespan and advanced evidence-based and scientifically-informed psychopathology, assessment, diagnosis, case formulation, psychotherapy, psychopharmacology, clinical evaluation and research across the full range of severity and complexity. We are well represented in high proportion amongst the innovators of evidence-based therapies, NH&MRC Panels, other mental health research bodies and within mental health clinical leadership positions.

It is abundantly clear that there the obvious significant gap in mental health service provision is for those in the community presenting within the range of the moderate to most complex and severe presentations. Those presenting with only mild presentations are unlikely to be affected by the cuts to session numbers. The treatment of the moderate to severe range is the unique specialised training of the Clinical Psychologist and, to undertake a comprehensive treatment of these individuals, more than thirty sessions per annum are sometimes required. In this way, Clinical Psychologists should be treated as Psychiatrists are under Medicare as both independently diagnose and treat these client cohorts within the core business of their professional practices. However, this is unlikely to be granted presently given the government imperative to cut costs so we believe that the decision to cut session numbers for the specialist clinical psychologist Medicare items should be reversed immediately.

In addition, a number of other points are outline below:-

- (a) We are specialists – it is only in the clinical training program that the clinician is systematically exposed to clinical theory and practice with different client populations in the application of assessment, case formulation and treatment of various mental health disorders. Enhancing expertise by investing in post-graduate clinical training programs ensures that consumers receive assessment and treatment services from comprehensively trained practitioners. Remuneration, in the form a higher rebate would be commensurate with the advanced level training and clinical supervision pursued by Clinical Psychologists. Reducing rebate would have wider ramifications in terms of eroding the value of pursuing advanced training.
- (b) Clinical Psychologists receive eight years (6+2) of specialist training in the assessment and treatment of mental health. Those with six years of generalist training (4+2) have been provided the opportunity to have their expertise assessed by the Clinical College to be equivalent and hence have had their supervision and workplace training acknowledged. Those who have not met the criteria have been offered a bridging plan to allow them to develop the competencies required to join the Clinical College.
- (c) If there is one tier system, it should be for more advanced training to be recognised – clinical psychologists only get the rebate.
- (d) Profession is moving towards higher levels of training as a basic requirement for registration and employment in the public health system. Internationally, there is a trend for registration only being offered to those with doctoral level qualifications.
- (e) If we bulk bill those clients on health care cards then private practice becomes unsustainable. Meaning that psychologists are less likely to bulk bill or to charge a gap fee. This will affect the accessibility of young people with limited financial means and those who are impoverished to quality mental health care.
- (f) There are far-reaching medium term impacts on the training of psychologists and the mental health workforce. If national mental health strategy is about increasing access to good quality care then reducing rebates runs the risk of reducing access to quality services.
- (g) Whilst cost savings are important so too is the recognition and respect for the expertise of the service providers.
- (h) Surely one likely result of reducing rebates and psychologists being less likely to bulk bill is that more pressure is put back on the public health system to service the growing demand for psychological services. Is this really a cost saving?
- (i) ATAPs fee is \$120 so why reduce the fee under the Medicare better access initiative? The APS recommended fee is \$218 per hour to cover the time used to prepare, score questionnaires, liaise with other professionals and report writing.

(2) Reduction in the number of treatment sessions available from 18 to 10 per year:

(a) There is a significant gap in mental health service provision is for those in the community presenting within the range of the moderate to most complex and severe presentations. Those presenting with only mild presentations are unlikely to be affected by the cuts to session numbers. The treatment of the moderate to severe range is the unique specialised training of the Clinical Psychologist and, to undertake a comprehensive treatment of these individuals, more than thirty sessions per annum are sometimes required. In this way, Clinical Psychologists should be treated as Psychiatrists are under Medicare as both independently diagnose and treat these client cohorts within the core business of their professional practices. The decision to cut session numbers for the specialist clinical psychologist Medicare items should be reversed immediately.