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To whom it may concern,

RE: Clinical Medicare rebate and reduction in number of Medicare funded sessions for psychology.

We would like to register our grave concerns regarding the Potential abolishment of the higher Medicare Rebate for Clinical Psychologists and reduction in number of sessions accessible to clients accessing services under the 'Better Outcomes' initiative.

We believe this move serves to undermine the current emphasis placed on higher education and training for psychologists.

A client who receives treatment from a Clinical Psychologist is guaranteed of two things:

- 1/ The psychologist will possess, at minimum, an APS accredited Masters degree in Clinical Psychology. And for many Clinical Psychologists, their training will actually include a Doctorate or Clinical Ph.D. level qualification.
- 2/ The Clinical Psychologist will also have undertaken a minimum of two years further training 'in the field', post graduation from their Masters level degree. This includes an additional 80 hours of individual supervision with a senior Clinical Psychologist and 80 hours of professional development 3080 hours of field practice while supervised (or 40 hours of supervision, 40 hours PD and 1540 hours for a Professional Doctorate graduate).

It should be noted that approximately that one third of Generalist Psychologists do not possess Masters or Doctorate level training and nor have they undertaken the same level of intensive field training and supervision post academic study as Clinical Psychologists. Of course, this fact is stated without the intention to neither disparage nor offend this group of Generalist Psychologists. However, from this stand point several questions are raised:

- 1/ What motivation would a Bachelor graduate psychology student have to pursue a higher level of training, considering the extra time and costs involved while undertaking both university based post-graduate programs and supervised field practice once generally registered, if there is no conceptual or remunerative recognition for this enhanced training?
- 2/ What motivation would graduates of a post-graduate Masters level program have to expend a further two years of field training, while fully registered and spending between \$8000 to \$12,000 on clinical supervision (depending on the charges of the senior Clinical Psychologist for supervision provided: which is typically between \$100 to \$150 per hour), if there is no conceptual or remunerative recognition for this enhanced training?



3/ And perhaps most importantly, what are the consequences for the patients with complex, multi-diagnostic presentations, if psychologists do not have real incentive to expend the *time and personal finances* involved in gaining enhanced academic and field based training? The answer in the long term can only be that many of these patients will not receive the level of treatment that their psychiatric condition requires.

We would also like to register our concerns regarding the reduction of Medicare funded therapy sessions available to patients on a yearly basis, from 12 (with potential for 18 'under exceptional circumstances'), to a maximum of 10. Clinical Psychologists specialise in the provision of mental health services to those in the community with the most complex and acute of psychiatric presentations. Often, these presentations include psychiatric problems in multiple diagnostic areas. Effective treatment of such complex presentations would be significantly hindered by such short-term and 'incomplete' therapy.

Under the Medicare system, psychologists are required to utilise Interpersonal Psychotherapy (IPT) or Cognitive-Behavioural Therapy (CBT) approaches, as the efficacy of these therapies has been confirmed by a plethora of research conducted over the last 70 years. Internationally recognised researchers in the development of these approaches (e.g., Aaron T Beck - CBT and Karl Weissman - IPT) assert that *at least* 12 sessions are necessary (Wells, 1997) and often 18 or more sessions are indicated (Weissman, Markowitz & Klerman, 2000) for 'standard' treatment to achieve a clinically significant therapeutic outcome, as well as justify the expense of services provided.

It is clear that the effective treatment of psychiatric disorder in the community, via Interpersonal (IPT) or Cognitive-behavioural Therapy (CBT) approaches, requires more than the proposed 10 sessions under the future Medicare funded system. A maximum of 10 sessions will impair the effectiveness of interventions provided to many Australians seeking treatment. From this stand point, several further questions are raised regarding the potential changes to the current Medicare funded system:

1/ If IPT and CBT are the indicated treatments for management of psychiatric disorder in the community due to their empirically confirmed efficacy, why would the Medicare system not allow for the necessary number of sessions these approaches require?

2/ Once again, what are the implications for our patients if the required number of therapy sessions cannot be accessed? The answer in the long term can only be that many patients will not receive the level of treatment that their psychiatric condition requires.

We hope that the Senate Community Affairs Reference Committee reconsiders its recommendation to remove the higher Medicare rebate in light of the above concerns, and that the Federal Government also reconsiders its position with regard to the reduction in number of sessions available to Medicare funded clients.

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References.

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