

August 4th 2011

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

To the Senate Committee investigating the Commonwealth funding and Administration of Mental Health Services,

I am a clinical psychologist with over six years post-graduate experience across a range of mental health services including Government Community Health, Child Protection and Private Practice. I am the Proprietor of a psychology practice in the Adelaide Hills region that provides professional psychotherapeutic services to clients in rural and suburban areas. Many of our clientele are from low-socioeconomic backgrounds and as such, are bulk-billed to reduce financial strain. We have both clinical and generalist psychologists working at the practice and to reduce any discrepancy for full-fee paying clients, we have ensured the “gap” is the same for all clients regardless of the practitioner they see (this results in reduced income for the generalist psychologists).

I wish to address a few areas currently under review by the Senate inquiry, the first of which is the two –tiered system under section (e) – (i) **The two-tiered Medicare rebate system for psychologists.**

The current Medicare system allows any registered psychologist to supply Allied Mental Health services provided they can attest that they have the relevant experience (no investigation is conducted into this) to access the Generalist rebate. This means that new graduates of Masters degrees in any area of psychology (forensic, clinical and organisational) as well as newly registered psychologists through the 4+2 (supervision) route can apply to provide Medicare services following registration.

Psychologists who can access the “clinical psychologist” rebate are required to meet a range of criteria that are of a far higher standard than that provided by newly registered psychologists. Access to Clinical Psychologist status requires a psychologist to hold a Masters degree in Clinical Psychology (a minimum of six years of tertiary training), a Doctorate (a minimum of seven years) or a Doctor of Philosophy (a minimum of eight years), followed by an additional two years of supervised full-time employment in a clinical environment by a clinical psychologist. In addition to this, it is a requirement that all clinically accredited psychologists have participated in extensive post-graduate professional development activities that meet the approval of the APS. Meeting this criteria is often rigorous, specialised and financially costly. In accordance with the requirements to maintain clinical endorsement, clinical psychologists are required to participate in a minimum of 45 hours of professional development each year in areas that have been endorsed by the APS as being relevant to professional practice with a minimum of 15 of these hours being recognised as clinically relevant (again this is time consuming and costly to practicing psychologists).

In contrast, generalist psychologists are only required to complete ten hours of professional development to meet the requirements necessary for the lower Medicare rebate.

I am aware of the highly emotive debate amongst the generalist and clinical psychologist population and have been concerned about the impacts of this upon my profession. While I believe that there have been many highly qualified generalist psychologists working within private practice who have been disadvantaged by this two-tier system, I believe the flaw lies within the manner in which the grandfather clauses and bridging processes were applied rather than inherently within the system itself. As with any place of employment, when we commence in new roles, it is expected that our skills level will attract a lower rate of income until we have increased our skills and competency with years of practice. Any government position I have held has had different pay scales across a range of professional levels. Currently the Government employs psychologists within the AHP stream which commences with level 2 (for registered psychologists – level one if people are still completing their Masters Degrees) and progresses through to level 3 and 4. To be employed at higher levels, positions need to become available, psychologists with the relevant experience and skills are requested to apply and a process of assessment for suitability ensues. This is not that different to what is required within the current two-tier system. Newly registered psychologists, regardless of their approach to registration, cannot be expected to have the same skill level as those who have had several years of field experience and further professional development and as such should not be able to access the same rebate. Further to this, I wish to note that Government agencies (the largest employer of psychologists) now predominantly require employees to hold Masters degrees as a minimum essential requirement to gain employment. This would suggest that these Government agencies hold greater value for training acquired through a Masters Degree program than that offered through the 4+2 process. This is possibly because of the need for psychologists with highly specialised skills in a clinical area that is not always offered through other programs.

Clinical Masters Degrees include training in a variety of clinical areas which include the use of a range of standardised psychometric assessment tools, therapeutic and proactive interventions, research and statistical analysis, critical analysis and a minimum of three clinical placements (all of which are several months long and require a minimum set number of client interaction hours). This range of clinically supervised placements exposes trainees to a variety of clinical environments that those through the 4+2 program are not exposed to due to being limited to the environment in which they have gained their two year supervision program.

Again, I believe it should be noted that many highly experienced and qualified generalist psychologists should have been approved for clinical endorsement based on evidence they were able to provide regarding their experience, skills level and further professional training. This is possibly an area for further exploration by the APS or PBA and perhaps there could be consideration given to re-opening the access for application to clinical endorsement through bridging programs and grandfather clauses to more equitably address this.

(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 Benefit Schedule.

The announcement of the government's intention to remove the "exceptional circumstances" clause to the Better Mental Health Care program caused myself and many colleagues significant concern regarding the impacts on many of our clients. While I agree, that those individuals with mild psychological health issues are unlikely to suffer greatly with the proposed reductions, many clients that I work with who fit the "moderate" to "severe" category could potentially be significantly harmed. While the government has indicated that the more severely distressed clients can access additional therapeutic sessions with psychiatrists (given that they are approved for 50 sessions per calendar year), this is not always a viable option, particularly for those who live in more rural areas. Even within more populated regions, psychiatrists appear to be more limited on the ground than psychologists, are not necessarily more skilled in the area of psychotherapeutic interventions (but

most certainly with medication) and their waiting lists are often extensive (preventing clients from accessing psychiatric assistance in a timely manner).

Mental health is a significant societal problem within Australia – the burden of mental health issues such as Depression, Anxiety, and trauma upon the community is substantial (a large percentage of clients seen have experienced significant domestic abuse and/or child sexual abuse – the impacts of which cannot be adequately addressed within 10 sessions). These mental health issues, when left untreated, impact on physical health, crime, productivity and mortality rates. Many mental health complications include complex comorbidity issues – i.e the presentation of individuals with substance abuse issues and post traumatic stress disorder or personality disorders– which cannot be adequately treated with such severe limitations on therapeutic sessions. Many clients which I have worked with over my years in clinical practice would benefit significantly with access to **more** than the previously offered 18 appointments rather than less. On a note that is more specific to the region in which I work – a significant number of suicides have occurred in the Adelaide Hills over the past few years which has brought considerable concern to psychologists working within the region (Strathalbyn in particular has attracted some media attention). This highlights the current inadequacy of the mental health system possibly through its reduced accessibility for more isolated individuals. While I do not believe that we will be able to prevent all suicides, provision of intensive and frequent psychotherapeutic sessions to those individuals at most risk is likely to have a beneficial impact on a reduction of these statistics. I therefore request that the Senate Committee pay careful consideration to their decisions regarding the reduction of psychotherapeutic appointments for this client group.

I thank you in advance for your consideration of my views regarding these issues.