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

Dear Sir/Madam

Re: Commonwealth Funding and Administration of Mental Health Services

I wish to address the following sections of the Terms of Reference for the above Senate in Reference Inquiry

(b) changes to the Better Access Initiative, including:
- (ii) the rationalisation of allied health treatment sessions,
- (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 Benefits Schedule;

(e) mental health workforce issues, including:
- (i) the two-tiered Medicare rebate system for psychologists,
- (ii) workforce qualifications and training of psychologists, and

(j) any other related matter

Section (b) changes to the Better Access Initiative, including:
(ii) the rationalisation of allied health treatment sessions,

As I understand changes from 1 November 2011, the number of allied health services will be reduced to 10 psychology services on an annual year basis.

- Although, some clients have clinical problems that can be resolved within the current limit of 12 services in a calendar year, a number of clients have on-going mental health issues that require more closer monitoring and more frequent attendance. What types of clients would require this? Clients who have unresolved severe depressive or anxiety conditions would fall under this category. Without presenting case examples to justify this the current number of services and the current extension provision of "exceptional circumstances" allowing for a maximum of 18 services a years should be retained.

- In addition, the conduct of some clinical therapies are limited by the limitation on the number of services. For example, the treatment of Posttraumatic Stress Disorder using imaginal exposure therapy cannot be resolved within 12 sessions, let alone the proposed reduction to 10, given that the protocol requires stabilization and engagement, psychoeducation, anxiety management, exposure therapy, cognitive restructuring, and relapse prevention. More than 12 services are needed. To reduce services will reduce effective psychological treatment of this mental health condition.

- It is to be noted that although the provision for mental health services under allied health is deemed to be for mild to moderate mental illness, people referred by general practitioners are often assessed, and this assessment is confirmed using clinical psychological testings, as having **severe** levels of depression and anxiety, for example, let alone associated psycho-social stressors that need treatment. Many presentations are complex and multi-faceted. However, we do not generally see people who have levels of psychopathology that would require admission to a psychiatric ward of a general hospital, which I assume is what is meant by *severe* in allied health Medicare Schedule terms.

Section 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 Benefits Schedule.

- Without presenting specific case studies the reductions of services will have a severe impact on patients.

- For example, referrals are made from public hospital psychiatric wards for on-going therapy for people who may have had an acute psychiatric episodes and require therapy beyond the follow-up period undertaken by hospital based Community Assessment Teams. This therapy

Section (e) mental health workforce issues, including:
(ii) workforce qualifications and training of psychologists, and
(i) the two-tiered Medicare rebate system for psychologists,

I have placed section (e) (ii) before section (e)(i) because I think that this is the logical stepping for my comments.

- It takes five years to train a psychiatrist in mental health post basic training (seven years for a MBBS plus internship) **a total of 12 years in all**.

- It takes four years (nominally) to train a clinical psychologist beyond basic training (four years for an honours BA or BSc or BBS plus four years for a Doctor of Psychology, **a total of eight**

years at university). In addition registration requirements have to be met.

- Other pathways to clinical psychology status, such as my own, have taken 10 years of university level training: BA(Hons) four years, Master of Psychology (Clinical) two years, Doctor of Philosophy (psychology research focus) four years). Registration requirements were three years post BA(Hons) making **a total of 13 years training** (14 if you include the MCrim (Foren Psych)! Please note that I was registered in 1980 on the basis of four years university plus three years experience but I realized that this was an inadequate level of training for clinical practice and so I began the long process of upgrading.

- So I ask, why are people being allowed to practice in the area of clinical psychology, working with patients with complex mental health problems, with a basic degree (either a BA or BSc or BBS) with a major in psychology and a Graduate Diploma in Psychology (one year) and three years experience to registration? Psychiatrists, five years post basic training; clinical psychologists (mental health training), four years post basic training; basic registered psychologist 1 year of post basic academic training.

- My point is that if both universities with clinical psychology training programs, and the Australian Psychological Society College of Clinical Psychologists membership criteria, now require DPscyh or equivalent academic standing as the standard for the practice of clinical psychology, why is the Medicare standard so low?

- I believe that psychologists with only minimal qualifications are inadequately academically prepared, and inadequately prepared in terms of therapeutic skills to undertake work with people who have even mild to moderate mental health conditions, let alone severe mental health conditions as identified in general practice referrals.

- What I believe should happen, is that, as with the Federal government requirements that kindergarten carers should all have a minimum basic qualifications, psychologists working within mental health and receiving a Medicare rebate should be required over the next five years to upgrade their qualifications to at least Master of Psychology level in order to continue to practice and receive a Medicare rebate.

- However, the difficulty I foresee with this idea is two-fold: (1) there are not enough clinical placements within the university structures to enable people with basic qualifications to upgrade; and, (2) some of the people who have basic psychology qualifications and psychological registration may not have reached the academic standards required by universities for entrance into a masters or doctor of psychology program. The later is a matter of particular concern because it means that people are currently practising psychology who are not academically assessed by the academy as the best candidates for undertaking psychological work in clinical psychology.

- Hence, these comments relate to the **e(ii) two-tiered rebate for psychologists**. The two-tired system should be retained for the following reasons:

    1. Effort to achieve higher qualifications and excellence in standard of clinical practice is a cornerstone of current rebates in the Medicare Benefits Schedule.

2. For example, specialist medical practitioners (surgeons and physicians) all receive higher rebates than general practitioners.

3. So also should psychologists who have trained at a higher level in clinical psychology.

4. The higher rebate indicates greater competence and training and this should be signalled to the general public through the higher rebate.

5. The higher rebate also gives an incentive for practitioners to better their basic training and to acquire higher levels of clinical skill as judged and assessed by the accepted training institutions in society, namely university level masters and doctoral programs.

(j) any other related matter

It is not a level, competitive, fair, referral playing field.

The issue here is that a number (unknown) of medical practices rent out rooms to psychologists or psychologists pay a fee that includes rental of rooms and administrative services for each client referred in-house. My concern with this practice is as follows:

- It is an anti-competitive practice with the medical practice having a pecuniary interest in making in-house referrals.

- Psychologists in medical practice's rooms do not have to market themselves to the wider community.

- Psychologists can move into a medical practice from an area outside of the general practice and take away referrals from previously established practice relationships with non-in-house psychologists.

- Patients do not have an informed choice about psychologists in the local area from whom they make seek assistance.

- As such, patients are not given information about the practice areas, qualifications, and years of experience of the psychologist to whom they are being referred.

- Without naming medical practices, I have four examples in my local area where in-house referrals restrict open access to the overall pool of medical referrals from general practitioners. Note that under the Allied Health initiative all psychologists are dependent upon medical referrals.

- A proposed solution to these restrictive, anti-competitive, anti-market, pecuniary self-interested practice is as follows:

    1. Mandate that a Medicare referral to a psychologist be general without the specific name of a psychologist being made on the referral.

2. Mandate that under Medicare a general practitioners have to provide to a referred patient, the names of six local psychologists in their immediate area, and their contact numbers, from whom the patient may seek an appointment.

3. Mandate that the list of names should include information about areas of expertise (up to eight), qualifications, years of experience (when registered), registration status (whether or not specialist registration has been achieved), hours available, and billing practices. This information could be available from a central registry such as the Australian Health Practitioner Regulation Agency (AHPRA) web site with information updated annually as part of the annual registration process. The extent of information could thus be controlled. I also predict that this would provide an incentive to base grade psychology practitioners to upgrade their qualifications.

- I believe that if the above proposal was adopted then it would create a fair, free-market, competitive, and informed opportunity for patients to make informed choices about their mental health treatment options.

Yours faithfully,

Dr Anthony C Cumming
Clinical Psychologist

Author Competence

Dr Anthony Cumming holds qualifications in both Psychology and Theology. His psychological qualifications were completed at the Flinders University in South Australia. His *B.A. (Hons)* and *Master of Psychology (Clinical)* were under taken in the Faculty of Social Sciences (School of Psychology) and his *Doctor of Philosophy* was undertaken in the Faculty of Health Sciences (Psychiatry Department, School of Medicine). Dr Cumming completed a *Master of Criminology (Forensic Psychology)* degree at the University of Melbourne in June 2007. His theological qualifications were undertaken at the Melbourne College of Divinity for the *Bachelor of Divinity* and at the University of South Australia for the *Grad Dip Ed. (Religious Ed.)*.

Dr Cumming's doctoral dissertation is titled "Stress Among Anglican Clergy: A Clinical and Theoretical Treatise". His Master of Psychology (Clinical) research project was titled "Existential Concepts of Anxiety and Depression". He maintains an active interest in academic clinical issues and research.

Dr Cumming was first registered as a Psychologist in 1980 in South Australia, while working for the S.A. Government Mental Health Services. He subsequently studied for the Anglican Ministry and was ordained in 1987. He was registered in Victoria as a Psychologist in 1994 and has worked full-time as a Clinical Psychologist in Private Practice since 2001. Dr Cumming is a full-member of the Australian Psychological Society (APS), is a member of the APS Division of Independently Practising Private Psychologists, and a Member of the APS College of Clinical Psychologists, undertaking APS professional development activities within the College of Clinical Psychologists. He is registered to undertake clinical psychological work with the Victorian WorkCover Authority, the Transport Accident Commission, the Commonwealth Health Insurance Commission (Medicare) as a Clinical Psychologist, the Victorian Victims Support Agency, the Allied Psychology Services Project (Dandenong District - Division of General Practice), the Commonwealth Rehabilitation Service (CRS Australia) - Narre Warren, and with numerous Private Health Benefit Providers.

Dr Cumming was recently a psychological participant in the 2009-2011 Victorian Government Transport Accident Commission /WorkCover Network Psychology trial.