The Committee Secretary
Senate Standing Committees on Community Affairs
Re: Commonwealth Funding and Administration of Mental Health Services
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4 August 2011

Dear Senator,

I would like to comment on the following Terms of Reference of the Senate Community Affairs Committee's Inquiry into The Government's funding and administration of mental health services in Australia, with particular reference to the following two issues:

(b) changes to the Better Access Initiative, including:

(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 psychologist

The idea that the need for effective and evidence based treatment for those who are experiencing mental health issues continues to increase in today's society is rarely disputed. Challenges faced by clients who come for treatment by psychologists are on the increase. Taking depression as an example, the World Health Organisation states that depression is the fourth greatest cause of human suffering and disability around the world. The WHO has further asserted that by 2020, it will have risen to become the second greatest cause of human disability and suffering. Despite the increase in medication being administered for depression, it continues to be on the rise. Further, the economic cost from lower productivity, employee sick days and diminished job performance are significant.

Treating depression requires a complex set of skills and cannot be treated by medication alone. In fact there is increasing evidence that most of the therapeutic effect of antidepressant medications is attributable to the placebo effect, the response generated by a person's expectations alone rather than a true therapeutic effect of the drug. Even with an optimistic view of the effect of antidepressant medication, one must acknowledge that medication cannot teach the following:

- Social skills
- Empathy
- Coping skills
- Problem solving skills

- Goal setting
- Useful ways of thinking about themselves and the world they live in that will increase their outlook and their contribution to society.

I completed my Master of Clinical Psychology 14 years ago and am in private practice as a Clinical Psychologist. I work with a variety of clients with disorders not limited to depression, anxiety, complicated grief, relationship issues, post-traumatic stress, sexual abuse, substance abuse, Asperger's syndrome and Autism. I work with children and adults. I consider that I use a great body of evidence based theories and strategies in diagnosing, treating and assessing such a diverse range of people from a wide variety of age groups and with a vast array of problems and disorders. I believe that it is this breadth and depth of work that I do including working with those with severe mental health disorders that distinguishes me as a Clinical Psychologist.

Further, Clinical Psychologists are provided with training to develop their flexibility and discrimination in knowing when, with whom and how to apply the wide variety of skills, theories and strategies, as each person requires a truly unique therapeutic plan, while acknowledging overlap in strategies provided.

In order to do this effectively, Clinical Psychologists complete a minimum of six years of university training with two additional years of mandatory professional supervision, hence 8 years of training in total. With the exception of psychiatry, clinical psychology is the only other mental health profession whose entire post-graduate training is in the area of mental health. Clinical psychology is the only discipline whose complete training is in psychology (undergraduate and post-graduate studies). A further distinction from generalist psychologists is that the emphasis of clinical psychology is on severe mental health problems and all of the assessment, diagnosis and treatment issues that are involved for these clients. Clinical Psychologists have also been trained to adhere to stringent accountability measures.

In comparison, the training of generalist psychologists and allied health professionals tends to be geared towards general medical, general health or general community problems, with a short elective in mental health. Generalist psychologists are much less likely to have worked in clinical setting such as hospitals and as a result, they may not have any experience diagnosing and treating patients suffering with more moderate to severe mental health issues.

As is evident from reading other submissions already made, there is considerable appreciation from some clients who have stated how grateful they have been to be able to access private practice therapy rather than having to come into the hospital system. By ensuring and supporting Clinical Psychologists in the private system, it is ensuring that clients can access this type of support without feeling that they have to enter a hospital system which can be far less comfortable for many clients. In this way, even clients with very severe conditions can be co-managed between the psychiatrist, GP and clinical psychologist for a period of time, with psychiatrist sessions being spaced out further, thus leading to a significant cost saving.

In recognition of the greater experience and expertise of Clinical Psychologists, there are also greater membership costs and often greater costs for required specialised Clinical professional development when compared with costs for maintaining general psychologist registration.

Costs are significant in the running of a private practice. While more and more GP's appear to be referring clients only to those psychologists, who bulk bill, this means that an increasing number of Clinical Psychologists are receiving only $119.80 per client. I am sure that if a survey were done, it would show that for every hour of client contact to earn the above amount, a further hour is spent on administration costs including mandatory reports to GP's which do not attract a separate payment, phone calls, sessions planning and case notes as well as professional development including ongoing peer or private supervision. I acknowledge that in this case, generalist psychologists also face similar difficulties. At present, the current hourly recommended fee for psychologists as suggested by the Australian Psychological Society is $ 218. It has already become increasingly difficult for psychologists to make a reasonable living for themselves and there are many who have already given up on private practice and there will be many more if the situation becomes more difficult.

Considering the additional years of training, the higher expectations in regards to ongoing professional development and the often more complex case work conducted by clinical psychologists, it seems only reasonable that these differences should be reflected and recognised in the rates of remuneration between clinical and generalist psychologist.

I understand that there has been a small, but very vocal minority of psychologists that has gained a voice over the last few years, arguing that there is no difference between generalist and clinical psychologists' training, experience and work practices. I personally know respectable senior clinical psychologists in private practice whop have received multiple "hate" emails within the membership ridiculing clinical psychologists, making derogatory comments and attacking the Australian Psychological Society (APS). This group have spoken publicly, confusing the ordinary person and other professional groups including the referring GPs, who have had insufficient information about the situation. It has also come to my attention that threats have been made to publicly shame all clinical psychologists, who have lodged submissions to the review committee. This is simply bullying at its worst and this type of approach must cease as it only continues to damage the profession as a whole.

I believe that there is nothing unusual in a Clinical Psychologist being paid more than a generalist psychologist in the same way that such a system exists in so many other professions where greater levels of training are rewarded accordingly. At the same time, I am aware of some very well respected generalist psychologists in the field who would love to upgrade their skills to become Clinical Psychologists. However, there is no longer a route for them to do this as there was in the previous system where there was a way to upgrade through private supervision. This route ceased in 2010. It may be time to consider re-opening this avenue or to provide a similar way for experienced generalist psychologists to guide them towards obtaining clinical psychologist status without having to enrol in a lengthy postgraduate university course. This may also reduce the anger that some generalist psychologists feel, as they would have a way to move forward to increase their own qualifications. This is particularly the case for generalist psychologists who completed their training many years ago and would not even be allowed entry to a Master of Clinical Psychology course as the time that has elapsed since their undergraduate training is considered too long, providing them effectively with no option for further qualification in the field.

I would be grateful if the review committee would consider maintaining the current system of two-tier Medicare rebates, with the upper rebate representing an accurate and fair reflection of clinical psychologists' extensive training, qualifications and the specialist services provided to clients. Thank you very much for your attention to this matter.

Yours Sincerely,