Submission to Senate Community Affairs Reference Committee inquiry into Commonwealth Funding and Administration of Mental Health Services;

We have worked as clinical psychologists for over 14 years and for the past 3.5 years have been the Directors of a clinical psychology department within a major metropolitan public hospital. The department provides services to clients from a range of backgrounds, for a range of conditions. Waiting lists for all clinical psychology services within our hospital are significant, ranging from 3 months to 2 years depending on the service. Since the introduction of the Medicare rebate for psychological services we have seen a significant improvement in the wait time for some of our areas as we have been able to refer patients who would otherwise be unable to afford private psychology sessions.

We wish to comment upon two issues:

(a) the impact of reducing the number of Medicare covered sessions available from 18 (maximum) to 10 (maximum) and;

(b) the workforce qualifications and training of psychologists and existence of the two tier system of medicare rebates.

a. The suggested reduction of 18 (maximum) sessions to 10 (maximum) sessions.

Statistics indicate that only a small proportion of clients are seen privately for 18 sessions. However, it is clear that 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. **However**, these clients that do need these sessions have severe mental health needs, and if their mental health needs are not met, will potentially be the most costly to our community.

We would expect that if the maximum number of sessions is reduced to ten, these clients would be likely to be re-referred to our public service. This is unsatisfactory for several reasons: from a therapeutic perspective (changing therapists during a course of therapy is inefficient and difficult) and secondly, it is likely that clients who are re-referred back to a public service will be included on a wait list – thus interrupting their treatment often at a key stage and also potentially reducing its effectiveness. It will also increase the demand for our public psychology services, subsequently requiring additional funding for these services to enable us to meet demand.

Secondly, many of the evidence based protocols used to treat severe anxiety and depression require 12 – 18 sessions of treatment. For people in this category, there is no way of “speeding up” treatment. Instead, if there are only have 10 sessions available, psychologists would have to make a decision as to what parts of treatment to omit. By reducing sessions, treatment not only is sometimes forced to become less comprehensive and therefore arguably less effective, it now becomes less than evidence based.

We do not work as private practitioners and therefore clearly our support for maintaining the maximum number of sessions at 18 is not financially based. We have provided this submission because we believe strongly in the needs of this particular client group, and our belief in the benefit of comprehensive psychological therapy in reducing costs to the individual and the community.

b. Qualifications and Training of Psychologists and the Existence of the Two Tier System

We believe it is essential that psychologists in Australia be required to undertake extensive training and supervision. 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. In addition, extensive training and supervision is required to maintain international standards (In the UK and the US, psychologists have a minimum of 6 years and up to 10 years of full time training, even before post study supervision requirements).

Given the above, we believe we should be aiming for **all new psychologists** to be required to obtain a Masters degree (6 years) in psychology (which includes active psychotherapy supervision) *and* extensive ongoing professional development requirements, *and* post degree (2 years) supervision requirements. In contrast, a four year undergraduate degree plus a highly variable supervision quality/amount (as held by non clinical/generalist psychologists) is often not sufficient training. It is likely that there are non-clinical/generalist psychologists with many years of experience, but as a general standard for training in the future, it is not sufficient.

This is highly relevant to the current senate inquiry in terms of the two-tier medicare rebate. In effect, by having a two tier system and having a higher Medicare rebate for clinical psychologists, it encourages a higher level of training and supervision.

With a single tier system, and a single medicare rebate for non-clinical psychologists, we are in effect informing new psychology students that there is no financial advantage in obtaining a Masters degree, and no financial advantage in being a clinical psychologist with the additional training and supervision requirements. We suspect this will increase the number of non-clinical/generalist psychologists in Australia and reduce the number of people committed to the more arduous path of clinical masters/ongoing eligibility for clinical status. **Hence we gradually, over the next few decades, become a nation with lesser trained and skilled psychologists.** The decision to revert to a single tier system may well have negative implications for the mental health of our nation for decades to come.

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.

A note about outcome research: There has been some argument by generalist, non-clinical psychologists that the recent medicare survey showed that there was no evidence that clinical psychologists produced superior outcomes to registered psychologists.

We would like to reassert that there were many flaws (as has been highlighted by other submissions) in this very introductory study, and it has never been replicated anywhere in the world.

We'd also like to point out that an important aspect of this study was that the generalist psychologists surveyed in this study were highly likely those with **many years of experience**, whereas the clinical psychologists in this study were highly likely to have a **spread of years of experience (both less**

and more experience). The reason for this is that in the past, it was less common to obtain a Masters degree/clinical status and therefore, there are significantly **more older** generalist psychologists practising in private practice than there are **younger** generalists psychologists, as in the past, clinical training was less common.

If it could be concluded that the generalist psychologists in this study produced equivalent outcomes to the clinical psychologists (and again, given the flaws of this preliminary survey, that would be difficult to do) **it must not be assumed that this was because the clinical psychology training and generalist psychology training are equivalent**. Instead, it is more likely to have occurred because the generalists psychologists of this particular survey, given their demographic, had more experience overall than the clinical psychologists, simply because of their particular demographic.

Thank you for considering our submission.