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

28th July 2011

Re: Senate Community Affairs Reference Committee Inquiry into Commonwealth Funding- Administration of Mental Health Services

I wish to make a submission into regards to the proposed changes to the Medicare Better Access Scheme, in particular, the lowering on the number of Medicare rebatable sessions from 18 to 10 and the lowering of the applicable Medicare Rebate for Clinical Psychologists.

Firstly, in relation to the reduction of Medicare Rebatable sessions to 10 per year, it is questionable why clients who are being successfully treated under the Medicare Better Access scheme should be asked to transfer to alternative schemes such as the ATAPs (Access to Allied Psychological Services) program to continue treatment. This program also has its own funding issues. I have been made aware that the ATAPs funding for the East and Adelaide division area for example, was exhausted 2 months prior to the end of the financial year. Clients therefore had to be encouraged to move over to the Medicare Better Access Scheme within this period in order to continue receiving psychological counselling. It appears illogical to ask clients to move onto an alternative program where further funding issues may require them to move back to their original program!

Secondly, there are a number of points to consider in regards to the lowering of the current Clinical Psychology rebate. Firstly, graduates of Clinical Psychology courses have been specifically trained in the assessment and evidence-based treatment of mental health issues, as well as psychopharmacology, all of which are essential to our work under the Medicare Better Access Scheme. With respect to other types of Psychologists, such training is not a prerequisite in other streams of psychology and is not present in the training of Psychologists undertaking the conditional registration pathway. I myself undertook 1 year of conditional registration following my initial 4 years of training in psychology and I was not trained in these issues until I commenced a Masters of Clinical Psychology program. Many people such as myself commence Clinical Psychology programs due to their desire to specialise in the complex field of mental health treatment in the same manner as a doctor, for example, may want to specialise in a specific area. Medicare Practitioners are recognised under Medicare for their particular specialty and their rebates are set accordingly. It would seem prejudicial to not allow Psychologists that same option of specialisation, especially given that the Psychology Board of Australia has recently recognised and endorsed 9 practice areas of Psychology, including Clinical Psychology. To clarify, an endorsement on registration indicates that a Psychologist has expertise in an advanced area of practice in addition to the minimum level of

psychological training required for general registration. Thus it does not seem appropriate that Clinical Psychologists would be recognized for their advanced training and expertise in regards to mental health, but not be remunerated accordingly. Future possible Medicare items relating to other streams of psychology, should also recognize the advanced training of these Psychologists in their chosen area.

Secondly, most government Area Mental Health Services have recognised the specialist training of Clinical Psychologists for many years in their wage structure, setting Clinical Psychologist wage levels at a higher rate given the advantages of their training in relation to their job role. Having worked for such services, it is important to note that the tasks involved in working for such a service are almost identical to my current role in the private sector. On what grounds would it thus be appropriate to ignore the specialist training of Clinical Psychologists who work in the private sector? Why should Clinical Psychologists who chose to work privately be financially penalised as an arbitrary cost cutting measure?

Thirdly, I understand that the basis for the recommendations to cut Clinical Psychology fees resides in the recent outcomes study conducted by Medicare. This Medicare study was not specifically designed to assess the difference in the performance of Clinical Psychologists as opposed to Generalist Psychologists. Therefore, the information obtained was flawed, as it was not subject to the normal standards of research design. As would be expected of a study to determine any possible difference, it did not identify the nature, diagnosis or complexity of the clients by type of Psychologist, it did not identify the nature or type of psychological intervention actually provided, and it did not account for medication use by the client which can often make a large difference to treatment outcomes. It did not undertake follow-up assessment of clients, which is often the time at which the relative strength of any competent treatment becomes apparent and it did not determine relapse rates by type of Psychologist. Very importantly, it was a self-selected sample of Psychologists who self-selected their clients and clinically administered the research questions in session, therefore, it did not meet the basic research principal of random sampling.

I would appreciate your careful contemplation of the above points in relation to the current matters that are under consideration.

Kindest Regards,

Silvia Benovic
Clinical Psychologist