Dear Ministers,

I make this submission with the additional notation that I fully support the submissions made by ACPA (Australian Clinical Psychologists Association) and ACSP (Australian College of Specialist Psychologists), in each of which I hold membership. I would also like to emphasize particular points as per below.

(iii) the impact of changes to the Medicare rebates and the two-tiered rebate structure for clinical assessment and preparation of a care plan by GPs.

A great deal of Medicare money might be saved if GPs could simply refer to specialist psychologists as they do to any other specialist, without the current requirement to do a mental health assessment & plan and follow up six-session reviews. The specialist psychologists are those who meet the training standards and requirements to gain entry into one of the 9 areas recognized by the PsyBA, but for mental health would comprise Clinical and Counselling Psychologists.

These specialists should be retained on a higher tier, with the lower trained in a second tier with more restricted practices, as per the current system. For Clinical Psychologists and I assume other specialist psychologists, the GP assessment (as distinct from referral) is generally unnecessary since we routinely conduct our own assessments to determine treatment. GPs are not adequately trained in mental health to make anything more than the broadest identification of psychological problems, and are not at all trained to recommend a psychological treatment plan at the level of complexity that I work at. Clinical Psychologists are thoroughly trained in assessment and diagnosis and in general, the GP assessment is inadequate for my professional purposes. I understand that many have undertaken a short training of approximately 20 hours. That is akin to my doing a First Aid course and then expecting to tell a GP what his diagnosis and treatment should be. Even if the First Aid course was first rate, it would not make me a doctor. Nor does the GP 20 hours of training make a GP proficient in mental health. The professional expertise of properly trained and accredited Clinical Psychologists (and other specialist psychologists) must be recognized and respected. Currently it is not.

The requirement for a review every six sessions is a waste of time and money. I do not need a GP who is unqualified (or under-qualified in comparison to me) to review my work; it is inappropriate and invalid, and an insult to my professional capacity. The Clinical Psychologist is unpaid for the required reports, the GP has no qualifications to assess ongoing treatment and the patient has to bear the cost of extra visits that add little to their ongoing care. The referral and review process of GP referrals to psychologists is one of the most expensive components that could be done away with for specialist (endorsed) psychologists.

(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

(1) In relation to psychology services: the research has repeatedly and consistently shown that 15 to 20 sessions of treatment are required for common psychological disorders, like depression and anxiety, in order to achieve clinically significant outcomes for 85% of patients. The current 12-18 allowance is actually inadequate, but to reduce it to a maximum of 10 sessions in a calendar year is likely to result in the failure of many treatments; such a change ignores the research evidence, and as is therefore insupportable.

(2) Furthermore, if the assessment shows that the patient needs significantly more than the proposed maximum of 10 sessions then ethically treatment should be refused on the grounds that it cannot be completed within the available framework. Making it more difficult impossible to receive treatment can hardly be considered a step forward. To suggest that these patients will be better served in other programmes is naïve – the flood of people into psychological treatments with the advent of Medicare rebates in 2006 indicates the depth of need in the community. The government programmes aimed at the severely ill will leave a huge number of people without resources of any kind – again, a move that does not uphold the current push to promote the mental health of all Australians.

(3) There are also significant numbers of people who present to Clinical Psychologists with more complex psychological profiles and who will likely require treatment for significantly longer than 12 or even 18 sessions. They will not be appropriate for ATAPs programmes and will not have adequate treatment options under the new scheme. I have in mind here the many who present with depressions and anxieties that mask underlying pathology. They often present for something like depression due to relationship crisis (which is not a diagnostic criterion), do not meet psychiatric diagnostic criteria and therefore are not appropriate for ATAPs type of services, but whose work performance, wellness and parenting are significantly and deleteriously affected by their psychological condition. These people, who are many, are not adequately cared for anywhere except in private practices, where the fee has to be adequate to sustain the practice. At present I know of Clinical Psychologists who make an ethical decision to continue to treat people after medicare rebates run out, at greatly reduced fees but at cost to themselves. This country should not expect – even implicitly – that a professional specialty works for inadequate remuneration. Already the current Medicare rebate system for psychology makes no allowance to pay Clinical Psychologists for the time taken to prepare the required reports (though doctors are paid for the referrals they make – even when the practice nurse does the actual work or the patient merely fills in a K10).

(4) Neither the current nor the proposed systems make any provision for assessment sessions that are additional to treatment. Given that it can take 2-4 sessions to do a thorough assessment, the proposed change to 6 + 4 sessions leaves only 2 - 6 (maximum) sessions per year to provide treatment. This is simply undoable for all but those who have such simple problems they could probably do without Clinical Psychology intervention in the first place. My fear is that people will try to make do with what is available and the treatment outcome will be unsuccessful.

(5) The notion that only the “moderately” or “mildly” unwell need to be considered in providing rebates for treatment in the private practice sector appears to be based on nothing more than the need to cut costs in the Medicare scheme for psychology. It is not borne out by the experience of most properly and fully trained Clinical Psychologist, at least here in Western Australia where the figures are not muddied and confused by the issues to do with training. Clinical and Counselling Psychologists are the only psychologists whose entire postgraduate training is focused on clinical training. I cannot speak for Counselling psychologists and am sure they have their own voice, but I do know that Clinical Psychologists deal with many complex and co-morbid presentations as a matter of course in their practices. I would suggest that far from reducing the number of available rebates to their patients, the government would be wiser to increase the number of sessions so that treatment can be held securely from beginning to end. It does not uphold treatment to make it uncertain and inadequate due to lack of capacity to see it through. Again, complex and co-morbid cases will likely be seen outside of Medicare where the patient is able to afford it – this is discriminatory. For those who cannot afford it, a return to the hospital system and public mental health resources, such as they are, will be the only option. This will not be cheaper, as past experience has demonstrated.

For example, people with personality disorders who function just well enough to get by tend not to gain access to such programmes and often require long or repeated treatment. Because the disorder affects the person's capacity to function normally they usually cannot sustain paying for long-term psychotherapy. They tend move in and out of mental health services (hospitals, mental health clinics) for many years – hardly an effective treatment process and very expensive in the long run in terms of taxpayer dollars. Supporting them in accessing private practitioners who can do the long term work is the most effective and efficient way to deal with this sort of scenario – do it once, and do it right.

My recommendation is that the current system be retained, and improved by extending the number of sessions to at least 20, preferably extending it to cover a year of treatment.

(e) mental health workforce issues

(i) the two-tiered Medicare rebate system for psychologists

The two-tier system might be usefully retained if generalist psychologists (i.e. the clinically untrained four year degree psychologists) are restricted to the delivery of psycho-educational groups that might be quite cost effective. However, due to the lack of clinical training they should not be allowed to treat patients in any clinical sense and would need to be supervised by a clinically proficient person such as a Clinical or Counselling Psychoogist.

(ii) Workforce qualifications and training of psychologists

This is a vexed question due to the historical differences in different states regarding training. Australia has the most poorly trained psychology workforce in the Western world, with the lowest standards of entry to the profession for both psychologists and specialist psychologists. Around eighty five percent of psychologists currently practicing in Australia would not be able to practice in any other equivalent English-speaking country. Australia needs to move away from a much flawed training of 4 years in the science of psychology followed by two years of an unaccredited supervision program to a Masters entry level to the profession. Specialisation needs to move to Doctoral level training to bring Australian specialist psychologists into line with basic entry standards for the profession in the rest of the developed English speaking world.

Here in Western Australia we have had 35 years of a properly ordered system whereby only those with a university qualification in Clinical Psychology and other specialties can practice as such, and where workforce acknowledgement and recognition of the specialty has been longstanding. This is in keeping with international standards and makes for a safe and reliable system for referring agents and patients alike. The WA system should be adopted for the whole country – those who have long experience and can demonstrate equivalence can be grandfathered for a limited and defined period, then the problem will be over.

The recent 'levelling' of the field by the PsyBA to create consistency across the nation has been one of the most stunningly stupid backwards steps I have seen in all of my professional life, at least for those of here in Western Australia. The opportunity arrived to lift the standards to international level and it is being lost in the scramble to meet work force requirements and for eastern-staters to retain their status as Clinical psychologists without having the base training. A grandfathering system would be difficult to work out, but really it is the only way to resolve the issue of standards so that those from the 'older' unregulated system can be brought into the new system fairly and with reliable

maintenance of adequate professional skills. If a grandfathering system was imposed, the difficulties would be addressed and the whole profession could move on, with a clear set of standards and the unambiguous entitlement to specialist status – as is the case here in WA until 2013.

(iii) workforce shortages

If specialist practitioners are maintained as the deliverers of clinical (and other specialty) services there may be a shortage in the workforce for some years. However, dumbing down the profession is not the answer to this dilemma since the quality of ethical of treatment must be upheld. Other solutions will have to be found, and I refer again to the notion of grandfathering current practitioners with adequate experience who did not need to acquire the qualifications in past decades. If more specialists are needed then so be it.