I wish to address the following points from the Terms of Reference:-
(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 psychologists,
(ii) workforce qualifications and training of psychologists, and
(iii) workforce shortages;

(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

The limits on the number of sessions available to a client lead to some distortion and inefficiencies.

Patients with more severe mental illness may require more than the maximum psychologist sessions available under Medicare. As a result Medicare will often pick up the bill for a 6, 12 or more sessions which will ultimately be ineffective. The patient may then seek a service in the public mental health system where a longer course of treatment may be available. Treatment may start again with significant waste to the health budget overall. A reduction in the maximum number of sessions may lead to greater inefficiencies with a higher rate of incompletely treated patients seeking other sources of publicly funded care.

(e) (i) The two tiered Medicare rebate system for psychologists

This rebate system recognises the additional training which clinical psychologists have (6-7 years of university training including supervised practiced) compared with psychologists (4 years of university training and 2 years of supervised practice – the so-called "4+2" option).

Clinical Psychology is the only profession, apart from Psychiatry, whose entire accredited and integrated postgraduate training is specifically in the field of advanced evidence-based psychopathology, assessment, diagnosis, case formulation, psychotherapy, evaluation and research across the full range of severity and complexity in mental health. Clinical psychologists are well represented amongst the innovators of evidence-based therapies, NH&MRC Panels, other mental health research bodies and within mental health clinical leadership positions. For these reasons clinical psychologists are critical to the delivery of efficient, quality mental health services in the public sector.

I have been advised that, in Hunter New England Health clinical psychologists bring a more predictable set of clinical skills, a stronger grounding in theory, a greater awareness of and commitment to evidence based practice, a more thorough training in diagnosis, a more critical and self-reflective approach to practice and greater efficiency in service provision. This is a product of the centralised quality control in the university-based clinical psychology training courses. The supervised practice system does not deliver the same consistency or intensity in the development of knowledge base or clinical skills in those with 4+2 training. I completed the 4+2 training prior to undertaking my postgraduate training and so have experienced the difference between these two streams.

What has this to do with the two-tiered rebate system? Removal of a two-tiered rebate system would remove a significant incentive for would-be psychologists to undergo clinical psychology training which they do at significant personal expense. A decline in the supply of

clinical psychologists would have major negative consequences for our health system, particularly the mental health sector. Australians would suffer as a result.

(e)(ii) workforce qualifications and training of psychologists

Many western countries (e.g. UK, USA, NZ, South Africa, Canada, various European countries) require at least a Masters degree as a pre-requisite for registration and practice as a psychologist. Australia is alone in allowing those with only undergraduate psychology degrees to practice (independently) as psychologists. In Australia our training of clinical psychologists at Masters and Doctoral level is comparable to minimum standards in other countries. Many 4+2 psychologists would elect to undertake higher levels of training if training places were available. Currently, training paces are limited by the limited funding available to universities who often run these courses at a loss. Recent research has shown that if we could double the number of post-graduate training places we could meet the demand for (clinical) psychologists without needing to resort to the 4+2 option.

This would deliver a significant improvement in the quality of services provided in mental health and, by virtue of greater efficiency, a decrease in occasions of service per client and, therefore, greater service availability. The more highly trained clinical psychologists would get better results and generally get them more quickly than a 4+2 psychologist. But the bottom-line is that a minimum of 6 years of university training, as recognised elsewhere in the developed world, is necessary to train a competent clinical psychologist.

(e)(iii) workforce shortages

Currently in HNELHD management have trouble filling psychologist positions with clinical psychologists and this is a particular problem in rural areas. An increase in funding for training of clinical psychologists would improve supply generally and also redress some of the metropolitan regional/rural/remote imbalance in supply of clinical psychologists.

Thank you for considering this submission.