Committee Secretary
Senate Standing Committees on Community Affairs
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Dear Sirs, Madams,

RESUBMITTED CORRECTED VERSION

RE: HIGHER MEDICARE RATES FOR CLINICAL PSYCHOLOGISTS.

I will try to keep this short.

There is I suggest a basic, long established and well accepted principle in almost all areas of society, industry and work, of higher scales of pay for increasing or higher levels of qualification, learning, skill, expertise or ability. This principle is reflected in most if not all non-government and government employment and industrial awards, as well as in government/parliamentary areas directly (eg Backbenchers vs Ministers), and in professional work areas (eg GPs vs Specialists vs Surgeons, Solicitors vs Barristers vs Judges).

Without this principle and its inherent **incentive**, ie "higher rewards for higher level work", advanced levels of training, research, works and endeavour would most likely be not undertaken, and the lowest common denominator would be the norm. Is that what we want for our society and workforce? If it is, then I suggest our society would not be as advanced or developed as it is. The abundant evidence is that the principle of "higher rewards for higher level work" is the norm in our society.

Surely it is not unreasonable therefore that this same principle should be applied to the profession of Psychology?

Obviously this was recognised and implemented by the Howard government, and so may be sought to be unwound by some for that reason alone. However if the Labour government is willing to look at this principle non-politically, and not see it as a way to unwind what John Howard did, or attack Tony Abbot because he was Health Minister at the time of its implementation, but decide the issue on its merits alone, then the principle of higher pay for higher skill should surely continue, and maybe even strengthened

Using my own case as an example, I originally graduated as a Counselling Psychologist. During that time, I too thought it was "unfair that Clinical Psychologists should be paid more for the same work". I then did the substantial further academic work required by the College of Clinical Psychologists, and thereby eventually gained entry to the Clinical College and endorsement as a Clinical Psychologist. Unless I had done that extra work however, I would not understand, "that I did not know, what I now know". Thus prior to that extra learning, I was actually unqualified to say or know if I had the "same knowledge", or did do the "same" work, as a Clinical Psychologist, but plain old jealousy of them receiving higher rates, made me think I did.

Thus we cannot have the situation in any area or profession, including psychology, that it is accepted that one group of people are equivalent to others, just because ***they*** *think or say they are*. But I suggest that this is precisely what is happening in many of the claims now made by some non-clinical psychologists and organisations.

Higher academic standards have been set and recognised, just as they have been in other professions, that independently allow distinctions and determinations to be made, and advanced levels to be attained that in turn justify higher reward. And surely this is the only way such things can be organised and determined. Thus if non-clinical psychologists want the higher rewards, they are free to choose to do the specific and extra academic work, just as I did, to attain that. If they choose not to, then higher benefits should not apply.

Thus the assumption, and I suggest it is an assumption, that they do "the same work", cannot be fully substantiated.

Whist a clinical and non-clinical psychologist may employ the same in principle CBT model or methodology for say similar levels of anxiety or depression, that is no different than a GP or a Specialist/Psychiatrist prescribing the same anxiety or depression medication for a patient. The Specialist/Psychiatrist however, because of their further learning, will likely go much further or be more in depth with specialised treatment or medication, and especially or more so if the problem levels are "not similar". This is recognised and practiced by the medical profession by the very fact that GPs refer clients to Specialists for more advanced treatment. It is also recognised by the government in the higher Medicare rebates for Specialist treatment. But if the GPs did the "same work," there would be no reason for referrals or higher remuneration to Specialists.

Similarly, a Clinical Psychologist may recognise and treat a wider range of or rarer issues related to the general anxiety or other less general or less frequent conditions, based on that wider training and knowledge (eg Childhood and Pervasive Developmental Disorders, Autism, Aspergers, Dissociative Disorder, Somatic Disorders, Complex PTSD, to name a few) that a generalist psychologist may know of, but is not necessarily trained or experienced in.

Additionally, the claim by some the recent university study examining the Better Access to Mental Heath Scheme, "shows that there is no difference between clinical and non-clinical psychologist", is convenient and opportunistic for those seeking to demean Clinical Psychologists and negate their higher remuneration. There are many reasons, which others more experienced that I can, have, and will comment on in relation to this study, as to why the above and similar claims are unsound.

For one, in the version of the report published on the government's website, there is no statistical qualifying/analysis of the outcomes and related data as to quantitative, qualitative or statistical differences of the data (eg significance levels showing that numerical differences are in fact ***statistically*** significant). But some still claim a small or simple numerical difference proves their case, and that "there is no difference, and therefore no justification for higher remuneration to Clinical Psychologists". Such actually demonstrates a considerable misunderstanding, if not ignorance, of the data by some non-clinical psychologists.

Thus I submit that there is no substantive claim to sport the assertion that the current levels of Medicare rebates to Clinical Psychologists should be lowered. Rather, they should be unheld.

RE: CUTS TO BETTER ACCESS SESSIONS FROM 18 TO 10.

I also wish to express my objection about the Government's proposed changes to the *Better Access to Mental Health Care Initiative* (*'Better Access Initiative'*) as announced in the 2011 Federal Budget. Specifically, I am outraged by the proposal that from 1 November, 2011, the yearly maximum allowance of sessions of psychological treatment available to people with a recognised mental health disorder will be reduced from 18 to **10** sessions – almost a 50% reduction.

I was particularly galled by The Federal Minister for Health, Ms Nicola Roxon's explanation of these changes when last on the ABC's Q&A program. She stated that the numbers of sessions were simply being reduced from twelve (12) to ten (10), and thus it was of little consequence. Clearly this was completely misleading, and which I regarded as a direct lie given the above, but again it was classic Labour "spin", But considering the example of her leader Ms Julia Gillard saying "there would be no carbon tax in a government she leads", Ms Roxon's answer was not surprising.

Whilst new investments in mental health care are important and are to be applauded, they should not be at the detriment of existing mental health programs. For example, I understand that the Government has proposed to redirect funding from the *'Better Access Initiative'* to team-based community care (ATAPS). Personally, I do not agree with clients being mandated to participate in treatment involving multiple disciplines (i.e., psychiatry registrar, social worker, occupational therapist, mental health nurse) in order to access psychological treatment.

Under the existing *'Better Access Initiative'*, clients have been able to access and achieve very effective gains from psychological treatment without the utilisation of team-based care.

Therefore, I am deeply concerned as to how much those treatment gains will be adversely impacted if the funding for the *'Better Access Initiative'* is effectively halved (18 sessions to 10 sessions per annum) as it implies that the same treatment outcomes can be achieved with half the amount of sessions. The proposed cuts to the *'Better Access Initiative'* sadly reflects the Federal Government's lack of understanding of the specific and varied needs of Australians with mental health disorders.

Taking a hard line on mental health consumers is not the answer. It is unrealistic to expect individuals in a vulnerable psychological state to immediately establish a rapport with a mental health professional even within the current 12-18 sessions – let alone achieve treatment gains within 10 sessions. Clients do not need the added pressure or stigma of needing to recover quickly with the threat of being referred to a community team or psychiatrist and therefore having to start again with new practitioners.

It may also mean that some more serious presenting disorders may only be briefly or inadequately addressed; others may not be addressed if in the opinion of the therapists there will be insufficient time to ethically allow the opening up of issues related to deeper disorders, and if adequate closure or finalisation cannot be reasonably and/or responsibly achieved in that time. Thereby I suggest the cuts will significantly weaken the current effectiveness of the BAM program is important areas.

Senators / Ministers, I urge you to reject these proposals immediately and instead maintain the current amount of treatment sessions available with a Clinical Psychologist under the *Better Access to Mental Health Care Initiative* to be 12, with an additional 6 sessions for 'exceptional circumstances'.

LOWERING COSTS ELSEWHERE.

GPs are **not** paid to make referrals to other medical specialists, so why the need to pay GPs to make referrals to Clinical Psychologists? Clinical Psychologists, just as Psychiatrists, (but unlike non-clinical) are university trained and qualified to diagnose and psychologically treat mental health clients themselves. So apart from prescribing medication, the role of the GP in mental health work can be safely and considerably reduced.

GP referrals are almost always a one line referral for "opinion and management", and are computer generated in one or two minutes once the referral is considered necessary, if an Item 2710/2712 Mental Health Care Plan is not needed and did not have to be separately generated. I suggest therefore that a referral can be included in the general consultation fee payable for any visit to a GP, if a separate Mental Health Care Plan is not required.

Alternatively or additionally, allowing clients to directly access a Clinical Psychologist without the need for a GP referral (as per many other allied health professionals, eg Dentists, Optometrists, Physiotherapists, Chiropractors, etc etc), would save the government a far more substantial amount of money. I suggest this is possible, given that Clinical Psychologists have adequately demonstrated their integrity, reliability, and effectiveness with respect to Mental Health diagnosis and treatment, and good stewardship of Medicare funds.

In conclusion, I thank the committee for the opportunity to make this submission, and for taking the time to read it. I trust that my submission will be given due consideration. I commend it to the committee members.

Yours sincerely,

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