Dear Chairperson,

I am grateful for this opportunity to lodge this submission before the Senate Committee.

1. I would like to comment on "Item e" of your terms of reference that concerns workforce issues in psychology. Most of the comments I make were also presented in documents and reports I prepared for the College of Clinical Psychologists (one of the 9 Colleges of the Australian Psychological Society) in 2007 and 2008. I did this in my capacity as Chair of Course Approvals for the College of Clinical Psychologists (2006-2010). I can state that these recommendations had strong support within the College of Clinical Psychologists at that time and also with University Clinic Directors in my meetings with them through 2007-2009. It is important to clarify that the Australian Psychological Society is a much larger body representing psychologists and specialist psychologists. The College of Clinical Psychologists is one (the largest) of 9 Colleges. So the comments I make may or may not receive support from the broader APS organisation. Also, I have not checked with the current National Committee of the College of Clinical Psychologists to ascertain whether they continue to support these recommendations, but have no reason to believe they will not.

2. With regard to the Medicare-funded Better-access program, I am convinced that a cost-effective, workable, and efficient strategy that has short and long term benefits for all stake-holders (the public, students, training institutions, and Govt) is being overlooked. **Specifically, the recommendation is that the Government continue the current level of Medicare rebates to psychologists and specialist psychologists AND provide a lower level rebate for psychology services offered by psychology trainees at accredited sites (e.g., 34 University Psychology Clinics). It is argued that this will enhance outcomes of the Better-access initiative without increasing costs.** This funding innovation will:

    a. Facilitate the growth of the clinical psychology workforce, a stated Government objective
    b. Facilitate access to cost-effective mental health services in both urban and rural areas
    c. Protect and enhance the excellent standards of service and training offered by University Psychology Clinics
    d. Have long-term strategic outcomes, including nurturing the development of efficient, effective and cheaper treatments for mental health problems in the future.

**3.** The Government's Better Access initiative provides Medicare rebates to certain health professionals including psychologists and clinical psychologists. This has been a positive step in tackling the current mental health crisis, and has made mental health services more accessible and affordable to the community at large. However, this development has had an unintended impact on psychology training at University Clinics. Because clients favour Medicare-rebated services by approved and fully qualified psychologists to services offered by psychology trainees at university training clinics, referral numbers have fallen and referral types have changed, with some University Clinics suffering more than others.

4. Currently, there are 34-University Clinics offering psychology, mainly mental health services, to the community, with about 9,000 clients treated on a yearly basis. The clinics provide

excellent training to clinical and other non-clinical specialisations. This is because (i) Clinic Directors and clinical supervisors attached to these University training sites hold specialist clinical and training expertise, (ii) the clinics have state-of-the art facilities for audiovisual monitoring, assessment and feedback (video cameras, one-way mirrors, recording and feedback) to provide effective and efficient training, and (iii) staff with expertise in clinical supervision provide intensive monitoring and feedback to trainees during a developmental stage when trainees have not acquired the competencies to independently treat clients, especially vulnerable clients (e.g., persons with severe depression and suicide ideas). Such University-based training programs have, in the past, set standards of excellence in training, and have contributed to the development, research, trial and successful implementation of innovative treatment interventions, including several of the evidence-based psychological interventions used today. Hence it is important that such training programs continue and are supported.

5. The recommendation is that the 34 University Clinics be approved as Medicare-accredited sites, to enable trainees (e.g., clinical psychology and non-clinical specialisations if appropriate) to acquire site-specific provider numbers to offer Medicare rebates to clients treated at these sites. This training model is not new and currently applies to medical training (e.g., GP-registrar training, whereby GP-registrars are given site-approved provider numbers to practice under supervision). A large number of short and long term advantages are likely if the recommendation is adopted:

a) Workforce development: There is a significant shortage of mental health professionals including clinical psychologists. Several Government initiatives have sought to address this issue (e.g., by provision of postgraduate scholarships for psychologists in rural and regional areas & Health Workforce Australia's funding grants for placements). For several important reasons, the vast majority of specialist psychology training programs require students to undertake an initial placement in a University Psychology Clinic as an essential pre-requisite before they seek placements in external settings. Therefore, any initiative designed to increase the clinical psychology workforce will be successful only if training in University Psychology Clinics is strengthened and extended. In other words, the drop in referral numbers/change in referral types to University Psychology clinics is a bottle-neck, and will become a serious barrier to the realisation of workforce growth targets set by funding initiatives (e.g., HWA initiatives) that may work well for other disciplines. Currently, most Universities have to subsidise the cost of running Psychology Clinics which is a major disincentive to increasing training capacity. Also, students are often required to extend the duration of their placements in order to accrue the minimum number of face-to-face client hours prescribed by accrediting bodies. This slows down course completions adversely affecting meeting of workforce growth targets.

b) Access: The initiative will increase the community's access to mental health services. Close to 500 clinical psychology trainees undergo training at university psychology clinics annually. Several regional universities have campuses in regional/rural centres and accrediting these will assist in ensuring their financial viability and encourage the establishment of satellite clinics in regional/remote locations thereby extending access to deserving populations. Concurrent support for supervision innovations (e.g., e-supervision initiatives) will further help extend access to regional/remote communities. Currently, University clinics struggle to survive financially and have to be supported by injections of funds from Universities.

c) Cost-effectiveness: I would like to argue that the initiative will not significantly affect the budget bottom line. This is because most of the clients who would be seen by trainee

psychologists as part of the new initiative would receive medicare-rebated treatment from private psychologists anyway. In other words, the effect will be a relatively minor change in the way and to whom the Medicare dollar is allocated and disbursed, rather than to result in significantly increased costs. And, because trainees will be entitled to receive a lower rebate, a larger number of services will be provided for the same cost. The current disbursement of the Medicare dollar under Better-Access strongly favours the private sector. The services provided by the new initiative will continue to deliver quality services for the public, but will also be attractive to students and training institutions and therefore yield additional and desirable training outcomes (In colloquial terms, you get more bang for the Medicare buck).

d) Standards of care and training. University Clinics currently offer excellent standards of care and clinical training, and support from Medicare-rebates will help maintain standards.

e) Strategic value: Support for psychology training at university clinics is of strategic import. Because of the research and evaluation culture within universities, psychology treatments and training bear close adherence to empirical validated and effective treatment interventions. Over the years, the duration (e.g., number of sessions) and cost of treating common psychological disorders have reduced, making psychological treatments among the most empirically validated and effective interventions for mental health problems. The search for cheaper and more effective interventions for mental health problems is of long term value, and support for university clinics would be a strategic investment rather than a recurring cost.

Yours sincerely,

Associate Professor Craig Gonsalvez
School of Psychology,
University of Wollongong.