

Submission in relation to Commonwealth Funding and Administration of Mental Health Services

Below is my submission concerning the recent changes suggested in relation to the Governments funding and administration of mental health services in Australia. The submission specifically relates to the following two terms of reference.

- (1) TOR (b, iii): Changes to the Better Access Initiative - 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.
- (2) TOR (e, i) Mental health workforce issues - the two-tiered Medicare rebate system for psychologists.

(1) TOR (b, iii): Changes to the Better Access Initiative - 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.

Reasons why this change is not reasonable:

- I am very concerned about the decision to cut the Medicare rebated session numbers, especially the clinical psychology rebates. As a clinical psychologist, I have often been referred complex, and/or difficult clients from other mental health workers, general practitioners, psychiatrists and even generalist (non-clinical) psychologists. Such clients often present with severe mental health illnesses. The suggested 10 sessions would definitely not be enough to provide adequate care to such complex and severe clients. Such clients often require more than the currently available number of sessions (i.e., 18). Thus, cutting the available Medicare rebated sessions to almost half the amount would be detrimental to the care of such clients. Cutting the rebated session numbers would only make access to appropriate psychologist treatment difficult for clients with severe mental health problems.
- As mentioned above, often complex and severely mentally ill clients are referred to clinical psychologists not just from general practitioners and psychiatrists but also from other generalist (non-clinical) psychologists. This obviously is justified considering the extra education that is required to be qualified as a clinical psychologist compared to a generalist psychologist. A minimum of 8 years is required for a clinical psychologist compared to the minimum of 4 years for a generalist non-clinical psychologist. Thus, considering this extra education, qualification and thus, experience a clinical psychologist has compared to a generalist psychologist, it seems unfair and inappropriate to regard all psychologists as one level of skill or knowledge.
- Both in my experience and communication with other clinical psychologists, most of the clients accessing rebates under this Medicare scheme end up having only 6-12 sessions. Only a small percentage of severely mentally ill clients access all 18 sessions. Thus, cutting the number of Medicare funded sessions for clinical psychologists would not end up saving the government large amounts of money as cutting number of sessions will not affect clients with mild mental health problems. It would only compromise the health care of severely mentally ill clients for whom such rebates were originally considered for. As clinical psychologists are trained in and specialise in assessing and treating complex and severely ill mental health clients, the clinical psychology rebates should not be reduced. In this way clients with severe mental health problems would still be able to access treatment that they urgently need.

(2) TOR (e, i) Mental health workforce issues - the two-tiered Medicare rebate system for psychologists.

Reasons why this change is not reasonable.

- Clinical psychologists have been recognised as one of nine equal specialisations within Psychology. This is not only recognised in Australia but on an international level. These areas of specialisation are internationally recognised, enshrined within Australian legislation, and are the basis for all industrial awards.
- The clinical psychology specialisation requires a minimum of 8 years training. This is twice as much as the minimum 4 year training required by a generalist psychologist. My own training consisted of 9 years of study at university. The ongoing professional development activities that are required to be completed by a clinical psychologist exceed the amount required by a generalist psychologist. Thus, considering the additional qualifications, training and experience a clinical psychologist has over a generalist psychologist, it is unfair and inappropriate to propose that a generalist psychologist has the same level of skill and knowledge as a clinical psychologist.
- Clinical psychology is the only profession, apart from Psychiatry, whose entire accredited and integrated postgraduate training is specifically in the field of lifespan and advanced evidence-based and scientifically-informed psychopathology, assessment, diagnosis, case formulation, psychotherapy, psychopharmacology, clinical evaluation and research across the full range of severity and complexity. We are well represented in high proportion amongst the innovators of evidence-based therapies, NH&MRC Panels, other mental health research bodies and within mental health clinical leadership positions.
- As mentioned above, clinical psychologists are uniquely trained to treat moderate to severe mental health clients. In order to do this, a comprehensive clinical assessment and consequently treatment program is needed. This is similar to psychiatrists who independently assess and treat clients. This is often the core business of a clinical psychologist's professional practices. Thus, the current recommendation to cut costs (i.e., pay them the same as generalist psychologist) will drastically limit the work clinical psychologist can do especially for moderately to severe mental health clients who urgently need treatment. On the other hand, keeping the two tier system will ensure that clients with severe mental health problems are able to access clinical psychologists that are specially qualified and trained in dealing with such clients.