Submission to Senate Community Affairs Reference Committee inquiry into Commonwealth Funding and Administration of Mental Health Services;

I have worked as a clinical psychologist for 14 years and for over 10 of these years have been the director of a small group of clinical psychologists. We see clients over two sites in South Australia. In the last 12 months, we have had 260 clients attend appointments at our clinics.

I wish to comment upon two issues

(a) the impact of reducing the number of Medicare covered sessions available from 18 (maximum) to 10 (maximum) and;

(b) the workforce qualifications and training of psychologists and existence of the two tier system of medicare rebates.

a. The suggested reduction of 18 (maximum) sessions to 10 (maximum) sessions.

Only a small proportion of clients in our practice are seen for 18 sessions. However, these clients that do need these sessions have severe mental health needs, and if their mental health needs are not met, will potentially be the most costly to our community.

For example, I am currently working with a young woman with a severe and life threatening (as determined by medical specialists) eating disorder who when she first saw me, could not sit for more than 5 minutes at a time and was eating one or two pieces of fruit per day . As an 18 year old full time student, she would be unable to afford sessions without the Medicare rebates and has sought treatment only in the last year as a result of Medicare coverage for sessions having become available. She is an introverted and very private individual, who has never disclosed many of her struggles to any other person. She is currently at session 10. Whilst she has achieved significant gains in the last several months, if her sessions were to be stopped now, I honestly believe her life would be in danger. I am extremely relieved that it is "pre 1st October" and she has available another 2 – 6 sessions to consolidate the gains she has made.

I want to make three points about the need to have 18 sessions available to clients under Medicare.

1. The small proportion of clients who need 10-18 sessions do not choose to attend these sessions lightly. It costs them time and money to attend, it is painful, they are required to complete homework, they miss work and schooling and they only do so because they are desperate to have some relief from their suffering. There is absolutely no "overservicing" happening here, as clients themselves ensure it does not happen.

2. Many of the evidence based protocols I follow in treating severe anxiety and depression require 12 – 18 sessions of treatment. For people in this category, there is no way of "speeding up" treatment. Instead, if I only have 10 sessions available, I would have to make a decision as to what parts of treatment do I omit? Do I omit treatment about how to interact more helpfully socially with people? Do I omit the parts of treatment designed to prevent relapse? Do I omit the parts of treatment designed to help people identify their values? By reducing sessions, my treatment not only is sometimes forced to

become less comprehensive and therefore arguably less effective, it now becomes less than evidence based.

3. Clients "forced" to finish psychological treatment earlier than they wish, because of lack of medicare funding, may not only be more likely to continue to struggle with emotional and psychological concerns, but in addition may also be detrimentally affected by the shortened treatment itself. I can immediately think of several of my clients in the past, who have reported at some point mid treatment (ie session 10 for example) that psychological treatment hadn't helped them – it was only by the time session 18 had come around that they had come to see how they could use psychological strategies to help themselves. I believe that if these clients had been forced out of treatment at session 10, not only would they continue to experience psychological struggles but they would have also been negative about treatment, potentially more despondent about the likelihood of a positive future for themselves and potentially less likely to seek out psychological help in the future. All of this could well lead to catastrophic consequences in some cases for them, their families and communities.

4. Given that only a small proportion of people who need and want 10-18 sessions, it makes *minimal difference to our business financially* that 18 sessions be available. I emphasise this to demonstrate that my argument for 18 sessions is not biased by my own financial agenda. The reason I argue for 18 sessions being available is only for the sake of this particular client group – who suffer enormously and have no other options.

b. Qualifications and Training of Psychologists and the Existence of the Two Tier System

I believe it is essential that psychologists in Australia be required to undertake extensive training and supervision. I believe this is essential because of:

a) the depth of human suffering and the extent of this suffering (keep in mind that more people are killed by suicide in Australia than by road traffic accidents)

b) the incredible complexity of the human brain and human behaviour,

c) the need to be able to understand and conceptualise research, statistical method and the science/practitioner model

d) the ability to keep up to date with new research findings and practices

e) the ability to maintain international standards (In the UK and the US, psychologists have a minimum of 6 years and up to 10 years of full time training, even before post study supervision requirements).

Given the above, I believe all new psychologists who are wanting to treat mental health problems be required to obtain a Masters (ie clinical, counselling, educational or neuropsychology speciality) degree (6 years) in psychology (which includes active psychotherapy supervision) *and* extensive ongoing professional development requirements, *and* post degree (2 years) supervision requirements. Generalist psychology requirements (A four year undergraduate degree plus a highly variable supervision quality/amount and *furthermore a lower requirement of yearly supervision and professional development* requirements) are often not sufficient training in my view to do all of the above. It is likely that there are many generalist psychologists, with many years of experience, who are currently able to do the above, however as a general standard for training in the future, it is not sufficient.

In other words, if we want the best trained psychologists, we need to be ***phasing out*** *the provision of psychological services by people with this lesser degree of training and supervision.*

This is highly relevant to the current senate inquiry in terms of the two tier medicare rebate. Having a two tier system, in my view, is one very effective way of phasing out the provision of psychological services by individuals with this lesser degree of training and yearly professional development. In effect, by having a two tier system and having a higher Medicare rebate for endorsed (masters trained) psychologists, it encourages a higher level of training and supervision for all new psychologists.

With a single tier system, and a single medicare rebate for generalist psychologists, we are in effect informing new psychology students/potential psychologists that there is no financial advantage in obtaining a Masters degree, and no financial advantage in being a clinical (or other endorsed) psychologist with the additional training and supervision requirements. I suspect this will increase the number of generalist psychologists in Australia and reduce the number of people committed to the more arduous path of masters/ongoing eligibility for endorsed status. A single tier system means we gradually, over the next few decades, become a nation with lesser trained and skilled psychologists. The decision to revert to a single tier system may well have negative implications for the mental health of our nation for decades to come.

An important note about outcome research: There has been some argument by generalist psychologists that the recent medicare survey showed that there was no evidence that clinical psychologists produced superior outcomes to registered psychologists.

I would like to reassert that there were many flaws (as others have pointed out and I won't reiterate) in this very introductory study, and it has never been replicated anywhere in the world.

I'd also like to point out that an important aspect of this study was that the generalist psychologists surveyed in this study were highly likely those with many years of experience, whereas the clinical psychologists in this study were highly likely to have a spread of years of experience (both less and more experience). The reason for this is that in the past, it was less common to obtain a Masters degree/clinical status and therefore, there are significantly more older generalist psychologists practising in private practice than there are younger generalists psychologists, as in the past, clinical training was less common.

If it could be concluded that the generalist psychologists in this study produced equivalent outcomes to the clinical psychologists (and again, given the flaws of this preliminary survey, that would be difficult to do) it must not be assumed that this was because the clinical psychology training and generalist psychology training are equivalent. Instead, it is more likely to have occurred because the generalists psychologists of this particular survey, given their demographic, had more experience overall than the clinical psychologists, simply because of their particular demographic.

A true test would be whether in the future, generalist psychologists with say 10 years of experience produces equivalent outcomes to clinical psychologists with 10 years of experience. Given the extra work, training, supervision, time commitment, financial commitment and academic study the average clinical psychologist has put in, my bet would have to be on the clinical psychologists. This is why they deserve additional rebates, and why the future of psychology in Australia requires a two tier system.

A final note about the current generation of generalist psychologists: Given the experience of a whole generation of generalist psychologists, and the benefits they offer to mental health in Australia, we should be provided them with a way of accessing the higher medicare rebate. It is the future generation of generalist psychologists accessing the higher rebate which most concerns me, not the existing highly experienced practitioners.