

Friday, 5th of August 2011

Attention:

Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600
AUSTRALIA

Dear Sir/Madam,

Please find below my submission regarding the Better Access Mental Health Initiative enquiry regarding the Government's Funding and Administration of Mental Health Services in Australia. In particular this submission addresses the following two 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, and
 - ii) workforce qualifications and training of psychologists.

b) Reduction of Medicare Sessions from 18 to 10

In terms of the tabled reductions to Medicare funded sessions from 18 to 10 per year, much research and evidence has highlighted that further – not fewer – Medicare funded sessions are required. As the APS reports, “In the first three years of the Better Access initiative (2007–2009) 2,016,495 unique individuals received services from psychologists under Better Access and 262,144 (13%) of these people received more than 10 sessions of psychological treatment (<http://www.psychology.org.au/Assets/Files/07062011Better-Access-cuts-Briefing-Paper.pdf>).”

“The APS 2010 audit survey of 9,900 clients who required more than 10 sessions of treatment under Better Access shows that the vast majority had moderate to severe or severe mental health disorders involving depression and anxiety disorders, and that they received effective psychological treatment (<http://www.psychology.org.au/Assets/Files/07062011Better-Access-cuts-Briefing-Paper.pdf>).”

The APS Research results also reported that for those who received more than 10 sessions, "the research shows that by the end of their treatment only 3% remained severely affected, while for 43% of people their disorders were effectively reduced to either no symptoms or only a mild presentation. How can it be seen as a saving to cut funding for these people who are clearly receiving effective psychological treatment under the Better Access program? (<http://www.psychology.org.au/Assets/Files/07062011Better-Access-cuts-Briefing-Paper.pdf>)"

Given the high prevalence of severe mental health presentations in the community and the implications of successful treatment, it seems incomprehensible that access to these services be reduced. Rather it is clear that access to funding should be increased for the community. Instead of stripping funding from Psychologists, it seems logical that funding that is currently spent on unnecessary referral processes (e.g. Mental Health Care plans by a General Practitioner who is not a trained mental health professional) or other sectors be removed, and direct access for consumers and additional funding redirected to psychological services that show efficacious treatment benefits to the community be increased.

E) The two-tiered Medicare rebate system for psychologists

Please consider my following submission addressing the terms of reference from the perspective of a Post-Graduate Clinical Psychology student. I will seek to address the current proposed submission to removal of the two-tier rebate structure for Generalist and Clinical Psychologists.

Before doing outlining my concerns regarding the submission to remove the two-tier rebate system for psychologists, I wish simply to state that my submission does not seek to undermine any speciality in the psychology profession. I highly value and recognise the professional contribution of each stream within psychology. Rather I simply seek to highlight to the Committee the professional differences that validate a two-tier rebate structure.

I will not address all of Terms of Reference. Rather I wish to address the items throughout my submission:

- Clinical Psychology training program beyond Generalist Psychology training
- the existing international definitions of Clinical Psychology, stating it's distinction to other mental health professionals;
- the role of government in supporting the education of Clinical Psychologists, and;
- the benefits of maintaining a two-tiered Medicare rebate system.

Clinical Psychology and the training Program

In Australia, the tertiary education system, in conjunction with the Australian Health Practitioner Regulation Agency (AHPRA) and Australian Psychological Accreditation Council (APAC), has

developed the Australian standards for Clinical Psychology training to more closely align national professional standards with those established internationally. As these standards have been established and endorsed by Australia's psychological accrediting bodies, it would be inconsistent for the government to undermine the established practicing standards. Specifically, under the current APAC Accreditation Standards, I am required to undertake both undergraduate and post-graduate training in the field of Psychology to be endorsed by the College of Clinical Psychology.

To qualify, to date I have completed a Bachelor of Arts (Psychology); Bachelor of Arts (Honours – Psyc), and I am currently in my ninth year of university completing a Doctorate of Clinical Psychology. As a result of my extensive training, I have received specialist training to conduct clinical assessment, diagnosis and treatment of presenting psychopathologies. At the completion of my studies, I will have completed:

- 1500 hours of professional practice
- 600 hours of client contact
- 230 hours of specialist Clinical Supervision
- Specialist clinical coursework
- A doctoral level research thesis

My level of training and specialisation is only matched within the profession by Psychiatrists. As a result, our clinical skills to treat mental health conditions are highly regarded and add unquestionable value to the mental health care system. In contrast, while Generalist Psychologists (registered following 4 years undergraduate study + 2 year internship program) provide immense value to the treatment of psychological conditions, given the level of professional training I have received, this dispels the presumption that there is no professional distinction between Clinical and Generalist (4 + 2) Psychologists.

International recognition of Clinical Psychology

In fact, the role and benefits of Clinical Psychology have been recognised internationally by a number of organisations. For example, the Clinical Psychology Workforce Planning Report published by NHS Education for Scotland states “Psychological interventions can be delivered by a variety of health professionals. The role of the Clinical Psychologist therefore includes developing and evaluating interventions for delivery by others; consultancy and supervision to colleagues providing these interventions as well as delivering a direct service to patients with more complex psychological problems”. Similarly, the American Psychological Association notes that “What distinguishes Clinical Psychology as a general practice specialty is the breadth of problems addressed and of populations served”. The British Psychological Society argues that the specialist training that Clinical Psychologists receive facilitates cross-disciplinary conceptualisation and management of individuals with mental health difficulties.

Possible implications of the removal of the two-tier Medicare Rebate

Given the extensive training and specialisation of Clinical Psychologists, it would be unconscionable to argue that our level of training and speciality be financially penalised. Generally, Clinical Psychologists have received greater and broader clinical training, experience and supervision that mean we are mental health specialists. In my personal case, I will have completed 3 years more of specialist post-graduate training, and inherent in further study is extensive financial sacrifice. In fact, due to the intensive nature of my post-graduate program and no available financial assistance when completing the DPsych program, this has resulted in an extremely limited financial income for the duration of my program as well as for the completion of all of my degrees. While I have completed my level of training because I am passionate about psychology, the current two-tiered rebate structure recognises the different levels of training, experience and speciality between Generalist and Clinical Psychologists. The removal of the rebate would de-value my extensive additional training and specialisation.

What's more, I personally believe that to consolidate or collapse the current rebate structure to the generalist rebate would result in three outcomes.

First, it would undermine the additional training, experience and specialty of Clinical Psychologists in Australia. The equivalent in the medical context would be to equate the speciality and training of a GP with that of a Surgeon. Both specialities are unquestionably valuable and essential, however they are not equal. To remove the clinical rebate could ultimately mean a significant reduction in clinical psychology students and graduates due to the loss of recognition of the profession. With no professional recognition for additional training, this will certainly result in a reduction of expertise in the profession.

Second, it would mean that our clinical experience is neither recognised or valued and would vastly reduce the existing clinical presence and professional landscape.

Third, as mental health specialists it will mean that the community will ultimately lose access to services. As the Australian Psychological Society (APS) research on over 9,000 individuals who accessed psychological support over the last has highlighted, 84% of community mental health presentations were severe presentations (http://www.psychology.org.au/news/media_releases/7june2011). Given that Clinical Psychologists are specialised to work with severe and complex populations, the implications of the loss of mental health workers will be profound.

Hence supporting the education and training of Clinical Psychologists, and ensuring that a two-tiered Medicare rebate system remains, would arguably be a proactive stance to establishing an efficacious mental health service for Australians. It is apparent that to do otherwise would be disadvantageous, especially to those Australians with more severe or complex mental health issues – and arguably these are our most vulnerable citizens that Clinical Psychologists primarily treat.

Summary

In my above submission, I have sought to briefly address two Terms of Reference.

First, I briefly addressed the reduction of Medicare sessions from 18 sessions to 10 under the Better Access Scheme. To do so, I outlined:

- a) the outcomes of the latest APS research and highlighted that the loss of 8 sessions per year would significantly impact the community
- b) that funding should be increased and not decreased

Second, I have outlined my concerns regarding the proposed removal of the two-tier Medicare Rebate by outlining:

- a) the training standard for Clinical Psychologists in Australia
- b) the value of Clinical Psychology as a profession
- c) the possible outcomes if the two-tier rebate is abolished

Thank you for considering this submission in your inquiry.

Yours sincerely,

A concerned Doctor of Psychology (DPsych) Student.