

2 August 2011

Committee Secretary
Senate Standing Committees on Community Affairs
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Australia

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Terms of Reference

Senator Fierravanti-Wells, also on behalf of Senator Siewert, amended business of the Senate notice of motion no. 1 by leave and, pursuant to notice of motion not objected to as a formal motion, moved—That the following matter be referred to the Community Affairs References Committee for inquiry and report by 16 August 2011: The Government's funding and administration of mental health services in Australia, with particular reference to:

- (a) the Government's 2011-12 Budget changes relating to mental health;
- (b) changes to the Better Access Initiative, including:
 - (i) the rationalisation of general practitioner (GP) mental health services,
 - (ii) the rationalisation of allied health treatment sessions,
 - (iii) 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, and
 - (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;
- (c) the impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program;
- (d) services available for people with severe mental illness and the coordination of those services;
- (e) mental health workforce issues, including:
 - (i) the two-tiered Medicare rebate system for psychologists,
 - (ii) workforce qualifications and training of psychologists, and
 - (iii) workforce shortages;
- (f) the adequacy of mental health funding and services for disadvantaged groups, including:
 - (i) culturally and linguistically diverse communities,
 - (ii) Indigenous communities, and
 - (iii) people with disabilities;
- (g) the delivery of a national mental health commission; and
- (h) the impact of online services for people with a mental illness, with particular regard to those living in rural and remote locations and other hard to reach groups; and
- (j) any other related matter.

Dear Committee Secretary,

I wish to address the following points from the Terms of Reference (listed above):

(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,

(ii) workforce qualifications and training of psychologists, and

(iii) workforce shortages;

(b) (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

The limits on the number of sessions available to a client lead to some distortion and inefficiencies.

Patients with more severe mental illness may require more than the maximum psychologist sessions available under Medicare. As a result Medicare will often pick up the bill for a 6, 12 or more sessions which will ultimately be ineffective. The patient may then seek a service in the public mental health system where a longer course of treatment may be available.

Treatment may start again with significant waste to the health budget overall. A reduction in the maximum number of sessions may lead to greater inefficiencies with a higher rate of incompletely treated patients seeking other sources of publicly funded care.

(e) (i) The two tiered Medicare rebate system for psychologists

This rebate system recognises the additional training which clinical psychologists have (6-7 years of university training including supervised practice) compared with psychologists (4 years of university training and 2 years of supervised practice – the so-called “4+2” option).

Clinical Psychology is the only profession, apart from Psychiatry, whose entire accredited and integrated postgraduate training is specifically in the field of advanced evidence-based psychopathology, assessment, diagnosis, case formulation, psychotherapy, evaluation and research across the full range of severity and complexity in mental health. Clinical psychologists are well represented amongst the innovators of evidence-based therapies, NH&MRC Panels, other mental health research bodies and within mental health clinical leadership positions. For these reasons clinical psychologists are critical to the delivery of efficient, quality mental health services in the public sector.

Our experience in Hunter New England Health is that clinical psychologists bring a more predictable set of clinical skills, a stronger grounding in theory, a greater awareness of and commitment to evidence based practice, a more thorough training in diagnosis, a more critical and self-reflective approach to practice and greater efficiency in service provision. This is a product of the centralised quality control in the university-based clinical psychology training courses. The supervised practice system does not deliver the same consistency or intensity in the development of knowledge base or clinical skills in those with 4+2 training. We preferentially employ clinical psychologists because we get better value for money.

What has this to do with the two-tiered rebate system? Removal of a two-tiered rebate system would remove a significant incentive for would-be psychologists to undergo clinical psychology training which they do at significant personal expense. A decline in the supply of clinical psychologists would have major negative consequences for our health system, particularly the mental health sector. Australians would suffer as a result.

(e)(ii) workforce qualifications and training of psychologists

Many western countries (e.g. UK, USA, NZ, South Africa, Canada, various European countries) require at least a Masters degree as a pre-requisite for registration and practice as a psychologist. Australia is alone in allowing those with only undergraduate psychology degrees to practice (independently) as psychologists. In Australia our training of clinical psychologists at Masters and Doctoral level is comparable to minimum standards in other countries. Many 4+2 psychologists would elect to undertake higher levels of training if training places were available. Currently, training places are limited by the limited funding available to universities who often run these courses at a loss. Recent research has shown that if we could double the number of post-graduate training places we could meet the demand for (clinical) psychologists without needing to resort to the 4+2 option.

Our experience suggests that this would deliver a significant improvement in the quality of services provided in mental health and, by virtue of greater efficiency, a decrease in occasions of service per client and, therefore, greater service availability. The more highly trained clinical psychologists would get better results and generally get them more quickly than a 4+2 psychologist. But the bottom-line is that a minimum of 6 years of university training, as recognised elsewhere in the developed world, is necessary to train a competent clinical psychologist.

Clinical psychologists are trained at significantly less cost than are psychiatrists. They are more highly trained in mental health assessment than GP's and could be a less costly and more effective means of mental health triage, assessment, and treatment.

The most ready comparison of psychologists and clinical psychologists with other health practitioners is with the training required by medical practitioners. With regard to medical practitioners, all do a common undergraduate degree. They do common internship and residency practical experience. From there some go to general practice. Others go on to specialist training. The GP treats relatively commonly occurring conditions through medication and surgery. They act as a triage for more complex conditions which may be diagnosed and referred on for specialist management or referred on for further diagnostic work-up and management. The specialist deals with the more complex diagnostic and treatment issues.

Nevertheless, there is overlap between the work of the generalist and the specialist. For example, your GP may diagnose and remove a basal cell carcinoma. You could request referral to a dermatologist or plastic surgeon for further opinion and/or the surgical removal. This would cost you and Medicare more. What do you get for the extra cost? In theory you get a more expert job done. Greater certainty that the cancer has been entirely removed and that no more of you has been removed than is necessary and that you'll have less visible traces of the surgery. Ultimately, that may mean a lower overall cost to you and the system compared with if the GP didn't get it all and further surgery was required or the scar from the surgery proved so distressing that you required corrective plastic surgery.

The value-add of the specialist medical practitioner comes through considerable additional study, training and experience which is recognised in higher fees and a higher level of Medicare rebate. This parallels the qualifications, education, and skills associated with obtaining a post-graduate qualification as a clinical psychologist, compared to a psychologist.

(e)(iii) workforce shortages

Currently in HNELHD we have trouble filling psychologist positions with clinical psychologists and this is a particular problem in rural areas. An increase in funding for training of clinical psychologists would improve supply generally and also redress some of the metropolitan regional/rural/remote imbalance in supply of clinical psychologists.

In addition to the clinical psychology specialty, there is also an undersupply of clinical neuropsychologists. The majority of clinical neuropsychologists are trained in Victorian universities with a resultant imbalance in supply across the rest of Australia.

Yours sincerely,

Lisa Millar
Psychologist