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To the Senate Community Affairs Reference Committee inquiry into Commonwealth Funding and Administration of Mental Health Service,

I wish to offer comment on the Government's funding and administration of mental health services in Australia, with particular reference to:
(e) mental health workforce issues regarding the two-tiered Medicare rebate system for psychologists,

I hold a senior clinical psychology position in a leading psychology clinic in Gosford, NSW, called the READ Clinic. In this position, I supervise numerous psychologists at various stages of training – from interns, to generalists to clinical psychologists. I also have a clinical case load which largely consists of complex child and family cases, including my particular area of specialization in mental health in the perinatal period and early infant mental health. I see the majority of clients through the BAMH initiative.

I have also held positions as a clinical psychologist in various locations throughout the UK during the period 2001-2005. In one of these posts I was the lead clinician integrating the provision of mental health services into schools throughout South London. I also trained and supervised assistant psychologists and clinical psychologists. This has provided me a significant understanding of the role, the training and the skills of psychologist in another country.

There is no debate within our profession that Clinical Psychology is one of nine specializations within the discipline of Psychology, and one of the few that trains psychologists to be expert in treating mental health disorder. As such, I cannot understand the debate over whether it deserves a specialist rebate - as Clinical Psychology is the only profession, apart from Psychiatry, whose entire accredited and integrated postgraduate training is in the field of advanced evidence-based psychopathology, assessment, diagnosis, case formulation, psychotherapy, evaluation and research across the full range of severity and complexity.

As mentioned, I have worked with, trained and supervised a range of clinicians. There is no doubt that a clinical psychologists clinical skills are far superior to a generalists in terms of complex mental health assessments and treatments. I do not debate that a generalist has the skills to manage some of the less severe and less complex cases. There are some experienced generalists who have been working exclusively in mental health for many years who also have these refined skills. This is why I am not opposed to the idea that those generalists who feel they have the same skills as a clinical psychologist submit themselves to the same level of assessment of their clinical skills (through clinical supervision, written examinations and assessments). In this way, they too can indicate that their years of experience and post-graduate training has indeed taken their skills to a level the same as that which a clinical

psychologist obtains during their 2-3 years course work masters/doctorate degree and further 2 year supervised practice.

In the UK, clinical psychologists are the ONLY psychologists allowed to treat mental health presentations. It is very clear in the UK, as I believe it should be in Australia, that the reason for the areas of specialization is to protect the public and ensure best outcomes for the clients referred. There is no debate either in the UK or in Australia over whether a clinical psychologist should provide neuropsychology, nor sport psychology, nor forensic psychology (unless they have additional qualifications). We know our limits. We aim to work with the client group for which we were trained.

Whilst the data would be enormously difficult to ascertain, I could virtually guarantee that generalist psychologists working with BAMH referrals will ALWAYS prefer to seek their clinical supervision with a clinical psychologist. Why? Because whilst it is difficult for the generalist psychologist to admit in this current climate, the clinical skills needed to assess, diagnose and treat complex cases lies within the domain of the clinical psychologist.

To reduce rebates for clinical psychologists to that of lesser trained generalist psychologists would be a negative and irresponsible step that will have dire consequences for people treated for mental disorder in Australia. In medicine, a precedent already exists for the current two tier model. GPs will refer difficult mental disorder cases to a qualified psychiatrist who is a Fellow of the Royal Australian and New Zealand College of Psychiatrists. The two tier system in psychology is therefore in the best interests of the client and will provide the best treatment outcome on average.

My recommendation would be to

a) maintain current sessions limits to 10 sessions for generalists psychologists
b) maintain the current two-tiered system of rebates
c) Re-introduce the 18 sessions limit for clinical psychologists to enable them to see the more complex cases that we know simply don't get serviced either in a timely or appropriate way by the public health system. It makes no sense to enable up to 50 sessions per year for a psychiatrist and still maintain the debate that more serious cases should be seen within public health.

I suggest it would be a serious mistake for the Senate Committee to abolish a two- tier Medicare rebate system in psychology. If implemented, it would no doubt undermine the provision of services for mental health in Australia as well as the post-graduate educational system upon which the qualification of clinical psychology currently depends. I trust the Senate Committee will reach the most appropriate decision for the benefit of the Australia, the many thousands of clients who see clinical psychologists, and for the many thousands of clinical psychologists themselves who have worked hard and long to gain a professional and desirable qualification.

Regards

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