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Senate Standing Committees on Community Affairs
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Australia

Commonwealth Funding and Administration of Mental Health Services

I am writing to address specifically the terms of reference (b) changes to the Better Access Initiative (ii) the rationalisation of allied health treatment sessions; and (e) mental health workforce issues, including (i) the two-tiered Medicare rebate system for psychologists, (ii) workforce qualifications and training of psychologists.

Preamble

I am a Clinical Psychologist, with 8 years experience working as initially a Registered Psychologist (Bachelor of Science + Honours degree, + 2 years supervision) for 5 years and progressing to a Clinical Psychologist (Master of Clinical Psychology degree + 2 years Registrar training program). I am currently employed full-time as a Clinical Psychologist in the public health system, however, I am writing from my individual perspective and do not represent the views of the health department. I have a unique experience as working as a “4 year trained” Registered Psychologist and as a Clinical Psychologist – endorsed by the Psychology Board of Australia.

(b) Changes to the Better Access Initiative – (ii) the rationalisation of allied health treatment sessions

The recent Federal budget has seen the Better Access Initiative scheme under Medicare reduced from 12 sessions + 6 in a calendar year to 6 sessions + 4 in a calendar year. The concern I share is from the perspective of a Clinical Psychologist working full-time in public mental health and the effects of the change of access to psychologists (specifically Clinical Psychologists, see below) on presentations to public mental health services. The geographical area that I work in at present comprises a lower socio-economic area of Perth, with many disadvantaged people who live on the poverty line. The population includes Anglo/Caucasian Australians, Indigenous Australians, and many new arrivals to Australia where English is a second language. My experience over the past three years of the “12 + 6” scheme has worked reasonably well in creating a manageable workload for public mental health Clinical Psychologists. However, I often receive referrals from GP’s who have considered sending the patient to a private psychologist, but the patient is unable to afford even a modest gap fee (eg \$20 per session) or patients that have utilised all available Medicare funded sessions but require additional Clinical Psychologist input and are not able to fund this at private rates. These types of patients are in addition to the referrals we receive that have mental health disorders that are too severe to be considered for referral to a private psychologist.

My concern is that by reducing the previous access of 12+6 to 6+4 is the impact it will have on public mental health systems, particularly for patients requiring Clinical Psychology input. Anecdotally, I have already noticed a modest increase in referrals for Clinical Psychology input that can be put down to a combination of reduced access to Medicare funded private psychology services and the current global economy. I predict once the new initiative is in full-swing I will receive more referrals. The problem then becomes (i) managing a blow out in waiting times for access to Clinical Psychologists in the public sector, (ii) the flow on effect of patients waiting for psychological input presenting to GP’s or emergency departments in crisis, (iii) patients seeking cheaper, inexperienced or ineffectual treatment alternatives and

potentially protracting the distress for the patient. All of which comes at a greater cost to the government (state and federal).

I am also concerned about the information the government received to make this decision. The data the government used to analyse presentations to psychologists under the Better Access Initiative did not take into account the training or experience of the psychologist nor the type of mental health problem. The study appeared to rely on statistics related to number of sessions claimed, without examining reasons for neither drop-outs nor follow up of patients post discharge (i.e. recidivism). I refer the Senate Inquiry Committee to the research by Harnett, O'Donnell, and Lambert (2010, *Clinical Psychologist*) that identified 50% of clients took 8 sessions of Clinical Psychology intervention to show *reliable improvement* in their symptom presentation (full recovery took longer). Eight sessions, on average, would be considered the minimum amount to see improvement in patients, let alone full recovery.

(e) Mental health workforce issues – (i) the two-tiered Medicare rebate system for psychologists

In regards to the two-tiered Medicare rebate system for psychologists, I encourage the Senate Inquiry Committee to maintain the current system for several reasons. Firstly, the current system recognises the differences in skill set between Clinical Psychologists (Masters level trained plus 2 years Registrar training; “6+2”) and generalist Registered Psychologists (4 year Bachelor degree plus 2 years supervision; “4+2”). From my point of view, having worked as both a generalist Registered Psychologist, and as a specialist Clinical Psychologist, there is a significant difference in knowledge of clinical disorders, conceptualisation of problem formulations, and developing a tailored treatment plan. For generalist Registered Psychologists, the university training provided is theoretical background knowledge to the field of psychology, and from my experience, the 2 years supervision is based on trying to develop the necessary skills to perform the duties of a psychologist, without time for reflection of the therapeutic process, problem formulation, or developing a tailored treatment plan. From my experience, newly graduated 4+2 psychologists are more likely to adhere to manualised treatment plans, which are useful for mild, high prevalent disorders, but may be less successful for moderate to severe mental health disorders. In comparison, “6+2” Clinical Psychologists receive specialised training in psychotherapy during the Master’s course including intensive supervision during practicum, which includes placements across the lifespan (Child to Older Adult), combined with a 2 year Registrar program that involves supervision from an experienced Clinical Psychologist. A main concern that I have is that if the Federal Government changes the current system to one universal rebate fee, the incentive for further learning and developing specialist skills will diminish. There is a significant risk that by changing the rebate system the skill set of the psychology profession will reduce, potentially placing consumers of mental health services at risk.

Furthermore, there is a risk that a less skilled population of psychologists will place greater strain on GP’s trying to manage mental health patients and public mental health services, particularly in Western Australia as they employ Clinical Psychologists. There is a risk that the only way consumers of mental health services will be able to access specialist Clinical Psychologists will be through the public mental health system. If there is less incentive to continue with education and training to become a Clinical Psychologist, there will also be less opportunities for new Clinical Psychologists to find appropriate (i.e. Clinical Psychologists) supervisors, creating fewer Clinical Psychologists. This will significantly impact on the mental health workforce by de-skilling psychologists.

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

As mentioned above, changes to the Medicare rebate could have the effect of de-skilling psychologists by providing less incentive for psychologists to continue their education beyond the minimum requirement (currently a 4 year Bachelor degree + 2 years supervision). The “4+2” training model is recognised internationally as being an inadequate and out-dated apprenticeship method of training psychologists. Only Western Australia under the now defunct WA Psychologist Board recognised in law specialist psychologists such as Clinical, Counselling, and Neuro-Psychologist among others. This model, used for the past 30 years in WA, enabled a highly skilled psychology workforce, particularly in public health services, but also flowing on into the private sector. Private health companies in WA have recognised the difference in skill set in the private sector and do not provide rebates for Registered Psychologists, which is a true indicator of market forces (i.e. it is more cost effective in the long term to employ a higher skilled clinician).

It is recognised, however, that the “6+2” model (Masters level training plus Registrar training) is the minimum training level, with many countries such as the US and UK requiring doctorate level training. The newly created Psychologists Board of Australia has effectively set back Australia, particularly WA, 30 years of advancement of the profession by not recognising specialties (only endorsements, which are not clearly understood by the general public, and can be obtained without Master’s level training), and coupled with a universal rebate fee from Medicare will undermine the psychology profession. All of which places further costs and burdens of other aspects of the health system – GP’s, emergency departments, and public mental health systems. The Federal Government needs to enforce minimum qualification standards of Master’s level training plus 2 years Registrar training combined with 2 tiered Medicare rebates to ensure the ongoing advancement of the psychology profession.

Kind regards,

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