Senate Community Affairs Reference Committee Inquiry into Commonwealth Funding and Administration of Mental Health Services.

Dear Senate Standing Committee,

My submission will address two areas of concern:

1. Tiered rebate
2. The Government's plan to reduce the number of Medicare funded sessions under the Better Access Initiative

Two Tiered rebate

I support the clinical psychologists' argument not to have their Medicare rebate reduced as they do invest a significant amount of money and time to achieve their qualifications. Clinical psychologists also have to maintain professional registrations and fund ongoing mandatory annual professional development.

What I would like to bring your attention to is the fact that all non-clinical psychologists also invest heavily in terms of money and time to achieve their qualifications as well. Masters or higher programs are very expensive whether the person is training to be a clinical psychologist or within another field of psychology.

In addition all registered psychologists who have followed the 4 + 2 path are required to fund their competencies, professional development, and supervision without the benefits of HECS assistance and therefore have to "pay as they go". I have calculated that the cost of my 4 + 2 program will be about $16,000 by the time I have completed the program. That cost is similar to a masters program.

All psychologists are required to maintain professional registrations and fund ongoing mandatory professional development at the same cost as clinical psychologists.

I would therefore like to suggest that all psychologists, whether clinical or non-clinical, invest heavily in their education and must fund ongoing annual expenses and should therefore be eligible for the same Medicare rebate at the current rate that the clinical psychologists receive.

Furthermore, I have noted that some of the submissions presented by clinical psychologists are stating that only clinical psychologists are trained in research skills, assessment, diagnosis, case formulation, evaluation, psychometric testing and evidence based therapeutic interventions, most notably CBT or Cognitive Behaviour Therapy. This claim is simply incorrect.

All psychologists whether clinical or non clinical are required by both Medicare and by our own APS Code of Ethics to be fully competent in assessment, diagnosis, case formulation, evaluation and evidence based therapeutic interventions.

All psychologists whether clinical or non-clinical complete their tertiary education from universities who are required to only deliver accredited psychology programs which only teach evidence based skills. All psychologists in their fourth year are required to undertake research and write a thesis. In addition all ongoing supervision

programs and professional development are also required to teach evidence based skills. General psychologists are also trained in the delivery and interpretation of a range of psychometric tests as part of their registration requirements. To suggest that only clinical psychologists have been trained in these skills is incorrect and divisive towards the psychology profession as a whole.

Finally I would like to draw attention to the plethora of research that has consistently found that the most significant predictor of positive therapeutic outcomes is not the interventions alone but the client-therapist relationship or 'therapeutic alliance'. The therapeutic relationship between client and psychologist has nothing to do with whether the psychologist is a clinical or non-clinical psychologist; it is about the interpersonal skills, experience and human side that the psychologist brings to each and every client session. Clients are restricted in their choices of psychologists based on the two tiered model. I would like to suggest that we allow the clients to choose their psychologist based on GP feedback from previous client experiences and the psychologists' reputation as a professional rather than the choice be driven by level of rebate available to the client.

Number of sessions available to the clients.

I am very concerned about the proposed reduction in psychology sessions from 12 – 18 down to 6 – 10 with the suggestion that should the client require additional assistance that they be referred on to other services such as psychiatrists or ATAPS.

I would like to suggest that this would be very detrimental to the client based on the research discussed above; that the most significant predictor of therapeutic outcomes is the therapeutic alliance. To suggest that the client is 'moved on' after 6 – 10 sessions because they have not progressed fast enough would be sending the message to the client that they have somehow failed in 'getting better'. This could well have a negative effect on how the client perceives both the psychology profession as a whole and they may not wish to engage in further psychological assistance as they may feel it is not possible for them to improve.

Furthermore, all the psychiatrists that I have referred clients to in the past have had long waiting lists, up to 2 months, and most government funded mental health services simply cannot take on any more clients or are unable to provide the clients with the level of service they require, such as hour long therapeutic sessions. There would be a significant risk to the client that any progress gained to date would be lost whilst they are awaiting access to such services.

In addition I would like to suggest that referring clients on after 10 sessions should they require additional assistance would be a waste of funding as the client would then have to repeat all the work completed by the previous psychologist before they could continue with treatment. Psychologists cannot just 'pick up' where the last psychologist ceased treatment. A new assessment and treatment plan would have to be developed, the therapeutic alliance would have to be established, the client would have to feel comfortable retelling their issues (many of which are painful and traumatic,) therapeutic goals would have to be agreed and then treatment could begin. This would be a waste of funding when the original psychologist could have just

continued their work with the client and no disruption to the client would have occurred.