The Committee Secretary
Senate Standing Committees on Community Affairs
Re: Commonwealth Funding and Administration of Mental Health Services
PO Box 6100

CANBERRA ACT 2600

Email: Community.affairs.sen@aph.gov.au

4 August 2011

Dear Senator,

I have held continuous registration as a psychologist for the last 26 years and have been a full member with the Australian Psychological Society since 1991 and a member of the APS College of Clinical Psychologists since 1996. I started out working with adolescents with serious mental health issues, and then commenced a position as clinical psychologist within the division of psychiatry at a large hospital. Since leaving my hospital position, I have been in full-time private practice since 1992.

For the last 20 years at least, I have supervised a great number of entrants into the profession of psychology, who were working towards board registration as well as many psychologists applying for membership with the APS College of Clinical Psychologists.

I would like to comment on the following Terms of Reference of the Senate Community Affairs Committee's Inquiry into The Government's funding and administration of mental health services in Australia, with particular reference to the following two issues:

(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;

I would like to raise my concerns about the planned reduction of Medicare approved sessions from currently up to 18 down to a maximum of 10 sessions per calendar year. Many clients referred to my practice present with complex and moderate to severe conditions, requiring much more than 10 sessions per calendar year. Further, a considerable number of my clients are acutely suicidal and require at least weekly sessions until they are no longer at risk. It is potentially dangerous and not realistic to expect that these clients' appointments could be spaced 4-5 weeks apart. If clients are seen more than once a month and require treatment beyond the proposed maximum of 10 sessions per calendar year, psychologists will be presented with difficult ethical questions. As most clients cannot afford to self-fund their psychology consultations fully, can treatment be stopped abruptly in the middle of the year, just because a session limit has been reached? I believe that it would be detrimental to the therapeutic relationship to disrupt therapy at this point and advise the client to resume sessions in the new calendar year.

Psychologists have recently been informed that clients suffering from moderate and more severe mental health issues requiring more than 10 therapy sessions per year have the option of continuing with, for example, a psychiatrist for up to 50 consultations a year. I find it hard to believe that the transfer to a psychiatrist would represent a cost saving, especially since the new practitioner would yet again have to go through a lengthy assessment and rapport building phase with the client, who has already established a therapeutic alliance with the psychologist. Also, many clients would simply be unable to afford the substantial gap payment psychiatrists usually do charge. I work in a regional area with few psychiatrists nearby, and our local psychiatrists are usually booked out for many weeks. I doubt very much that they would be able to fit in the substantial number of clients who currently require more than 10 psychology consultations per year.

Apart from the cost factor and the practical difficulties of transferring across to a psychiatrist or organisation after completion of their 10 psychology sessions, many clients would not be prepared to accept such referrals to another professional or organisation. Clients are generally reluctant to "explain their story yet again" to the new professional and start afresh. Continuity of care is important to make the client feel safe and comfortable with the therapeutic process, to work towards therapeutic goals, to maintain progress made and to prevent relapse.

Although the current session limit of currently 18 psychology sessions per calendar year has not exactly been generous, this system has worked reasonably well for the last 4.5 years. Senator, I would like to urge you to not reduce the current number of consultations any further as it will place at risk the most vulnerable sector of the community, our people with moderate to severe mental health issues.

(e) mental health workforce issues, including:

(i) the two-tiered Medicare rebate system for psychologists

With the exception of psychiatry, clinical psychology is the only other mental health profession whose entire post-graduate training is in the area of mental health. Clinical psychology is the only discipline whose complete training is in psychology (undergraduate and post-graduate studies). This means that clinical psychologists are completely trained in a science intrinsic to mental health. The training of clinical psychologists differs in many ways from generalist psychologists and other allied health professionals. During the minimum of six years of university training with two additional years of mandatory professional supervision, the emphasis of clinical psychology is on severe mental health problems. Some students are completing either a Doctorate of Psychology with an additional formal year of training at the university, or a PhD in Clinical Psychology and thus adding a further two years to their formal university training. Clinical psychologists have extensive training in the theoretical, conceptual and empirical understanding of mental health problems and the thorough assessment, diagnosis, treatment and clinical evaluation of individuals with complex mental health problems. They have also been trained to adhere to stringent accountability measures. As a result of their training, clinical psychologists have a thorough understanding of a wide variety of complex psychological theories, and they have learned to formulate and respond to both, complex disorders and novel problems, generating interventions based on this solid knowledge base. This very high level of specialist competence of clinical psychologists is acknowledged by all private insurance

companies who recognise clinical psychologists as providers of mental health services. The training of generalist psychologists and allied health professionals tends to be geared towards general medical, general health or general community problems, with a short elective in mental health.

Clinical psychologists have often had considerable experience in working in clinical settings, such as psychiatric hospital departments or community mental health clinics. It is uncommon for generalist psychologists to be offered the opportunity to work in such clinical settings, and thus they may not have any experience in diagnosing and treating patients suffering with more moderate to severe mental health issues. Recently, a young male was referred to me, and within the first few minutes of listening to this client's account of his situation, I was able to comfortably conclude that the young man was suffering from symptoms of a drug-induced psychosis. During my years of working as a clinical psychologist within the division of psychiatry within a major hospital, I used to work with chronic schizophrenia sufferers and other patients, who were experiencing psychotic episodes. I have learned to easily recognise symptoms of thought disorder, delusions, hallucinations, paranoia etc. I might add that in the case of the above-mentioned new referral, the referring GP had not identified the young man's symptoms of psychosis. I was able to recommend to the GP the need for antipsychotic medication and a referral to a local psychiatrist. Whilst the client in question is waiting to see the psychiatrist, I have been providing psychological interventions and psychoeducation to the client and his significant others. Often clients with such serious conditions will then be co-managed between the psychiatrist, GP and clinical psychologist for a period of time, with psychiatrist sessions being spaced out further, thus leading to a significant cost saving.

Considering the additional years of training, the higher expectations in regards to ongoing professional development and the often more complex case work conducted by clinical psychologists, it seems only reasonable that these differences should be reflected and recognised in the rates of remuneration between clinical and generalist psychologist. In order to maintain their specialist registration, clinical psychologists also have higher overheads for membership fees and specialist professional development activities. Continuous professional development activities are often more costly and can be less readily available within the area the clinical psychologist is living in. At present, the current hourly recommended fee for psychologists as suggested by the Australian Psychological Society is $ 218.-. My experience has consistently been that per one hour of face-to-face consultation with a client, there is on average one hour of indirect, unpaid work associated with session preparation and follow-up, phone calls and liaison, record keeping and report writing and other administrative and professional duties. The current Medicare rebate for clinical psychology consultations is $ 119.80 per hour and for generalist psychology consultations $ 81.60. Please note, that the written reports all psychologists are required to send to the referring GPs after at least every six sessions as well as all liaison with the GPs and other providers does not attract a rebate at all. Should the clinical psychology rebate be abolished and clinical psychologists' clients would only receive the lower rebate of $81.60, then clients would have to be charged a substantial gap payment, which especially in this current economic climate, many clients could not afford. At present, I will agree to bulk bill services provided to disadvantaged clients, however, I could no longer afford to do this if the clinical psychology rebate would be reduced from $ 119.80 to $ 81.60. The introduction of a considerable gap payment would have significant, negative consequences for clients' access to

psychological treatment and potentially for their safety, as many of my clients are at risk of harming themselves.

Unfortunately, there has been a small, but very vocal minority of psychologists, which has argued for the last few years that there is no difference between generalist and clinical psychologists' training, experience and work practices. Sadly, this group has circulated many "hate" emails amongst members, ridiculing clinical psychologists, making derogatory comments and attacking the Australian Psychological Society (APS). This group has not hesitated to air their grievances very much in public, which has been confusing for the general public and other professional groups, including the referring GPs, who have had insufficient information about the situation. Interestingly, some of the supporters of this group have flatly refused to even consider the suggestion made by APS' representatives shortly after the introduction of the "Better Access" initiative, to consider bridging courses or ways to up skill via the non-standard route in order to become eligible for clinical membership. Until now, clinical psychologists have looked on silently as their colleagues have been trying to divide the membership and discredit the profession as a whole. This "rebel" group of psychologists has now threatened to lodge formal complaints about the "unethical conduct" of some clinical psychologists, who have tried to defend the two-tier Medicare system by sending a submission to the senate committee. Another threat has been to publicly shame all clinical psychologists, who have lodged submissions to the review committee. I believe that it is now high time to stop these unprofessional, unethical and undemocratic intimidation and bullying tactics.

I enjoy close and amicable contact with a large group of local generalist and clinical psychologists, and my experience has been that the great majority of generalist psychologists recognise and acknowledge the extra training and experience of clinical psychologists and seek out clinical psychologists for case discussions, ethical and professional matters, training, supervision and professional references.
I believe that it is a widely accepted concept that more specialised professionals attract higher incomes/Medicare rebates than their less specialised colleagues, with a periodontist charging substantially more than a general dentist, or a psychiatrist's or oncologist's Medicare rebate being higher than a general practitioner's. It has been argued that there are other specialised psychologists within the profession whose clients cannot receive the higher Medicare rebates. I believe that clinical psychologists have the best matching training and experience to work with the moderate to severe end of the conditions included under the "Better Access" program. Other groups of specialised psychologists have different earning opportunities clinical psychologists may not be able to access, e.g. organisational psychologists can negotiate excellent remuneration packages within the corporate sector, health psychologists can apply for senior positions within hospitals or Government departments, sports psychologists can coach successful athletes etc.

To recognise the many well-experienced generalist psychologists, who have taken it upon themselves to acquire additional skills within the area of clinical psychology, I would be supportive of a system that would offer these practitioners the opportunity to up skill and then apply for clinical psychologist registration, provided the eligibility criteria for APS College of Clinical Psychologists membership can be met. In fact, for the last 15 years approximately, whilst the non-standard route to membership with the APS College of Clinical Psychologists was still available to generalist psychologists, I

have been the clinical supervisor for many applicants and have enthusiastically assisted my supervisees to meet the requirements to upgrade to clinical psychologist. The non-standard route of applying for clinical psychologist status has been closed as from 1/7/2010, but maybe it should be considered to re-open it or to provide a similar avenue for experienced generalist psychologists to guide them towards obtaining clinical psychologist status without having to enroll in a lengthy postgraduate university course.

I would be grateful if the review committee would consider maintaining the current system of two-tier Medicare rebates, with the upper rebate representing an accurate and fair reflection of clinical psychologists' extensive training, qualifications and specialist services provided to clients. Thank you very much for your attention to this matter.

Kind regards