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To the Committee Secretary

Senate standing Committees on Community Affairs

## Inquiry into Commonwealth Funding and Administration of Mental Health Services

### Submission to the Senate Committee

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#### **My response to the Terms of Reference:**

##### Part (b)

(ii) & (iv) Treatment sessions should not be decreased to 10 sessions per patient as many of my patients require ongoing support. My experience of patients, even those with mild or moderate mental illness, is that they usually require a minimum 4 sessions in quick succession weekly, followed by another 4 sessions fortnightly, and followed by 4 monthly sessions. On many occasions this merely stabilises their situation and that ongoing monthly support is required to avoid relapses. Many of those suffering serious mental illness require regular supportive therapy to avoid relapse and potential hospitalisation. Indeed, such regular support will often assist in keeping families together and children of a mentally ill parent out of the Department of Child Safety care. Unfortunately, this level of care is currently not reflected under the Medicare limit of 12 sessions and would be even less so with the anticipated change to a limit of 10 sessions per year.

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## Part (e)

(i) I realise that in the real world the distinction in work performed by clinical and generalist psychologists is often hazy and sometimes non-existent. This is largely because both the psychology and medical professions have until recently failed to clearly distinguish between the seriously mentally ill patient and the one with general coping problems. In the not too distant past seriously mentally ill patients were referred to a psychiatrist; patients with coping problems were referred to a psychologist.

As society has become more aware of the extent of psychological problems within our population and governments have begun to realise the huge cost to our community, awareness has grown regarding the various levels of mental illness and the specific treatment required. It became clear that very specific training is required to deal with the seriously mentally ill cases. Hence the development of clinical psychologists as a specialist group within the psychology profession

In my experience there is a distinct difference between the generalist psychologist who treats patients with general coping issues and the clinical psychologist who also treats patients with serious mental disorders. Generalists who have been referred seriously mentally ill patients often flounder (and potentially exacerbate the patient's illness) because their training and experience have not equipped them with the necessary skills. On several occasions I have had to 'rescue' a patient from my generalist colleagues because they felt unable to help the patient. Without wishing to sound patronising in a sense I was also 'rescuing' the psychologist.

I believe there is a need for a two tier system to indicate the distinct difference in the levels of patient requirement and treatment. I also believe that the Medicare rebate should reflect this difference.

Tier 1. (Clinical) for those who are qualified to assess and treat patients with serious cases of mental illness including psychosis, bipolar affective disorder, eating disorders, dementia and clinical depression.

Tier 2 (Generalist) for those who are not qualified to treat patients with serious mental illness (even if in the past they have attempted to do so) but are qualified to deal with coping issues related to stress, anxiety, phobias, relationships, work, etc.

**(e)(ii) The critical difference between the two tiers lies in the training and experience required to qualify for that specific role**

Qualifications

- Training institutions clearly identify subjects which provide clinical knowledge and set specific minimums to achieve clinical status.
- Supervision of two years as a generalist is required before becoming a clinical psychologist
- All clinical psychologist should have a PhD or Doctorate, all generalist should have at least a Masters

Part (J) The Future

To allow all psychologists, regardless of training and qualifications, to treat people with serious mental illness would create chaos for the patients, the government and the profession. As society has long accepted the difference between GPs and Specialists in the medical field, so too will society accept that there is a need for Specialist psychologists for the most serious cases of mental illness. Society also accepts that the fee for visiting a specialist is higher than that for a generalist

Training of GPs and Psychiatrists should include helping them identify whether a patient requires a clinical or generalist psychologist.

Regards

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