

To: The Senate Community Affairs References Committee inquiry into Commonwealth Funding and Administration of Mental Health Services.

From: Ms Lindsay Image, Member of the College of Clinical Psychologists, The Australian Psychological Society (See contact details at end of submission)

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Summary of submission: Provision of an example of one person's experience and training as a clinical psychologist and its application in a private practice setting, using case examples from one week showing the need for specialist training at a higher level than needed for base grade generalist psychologists..

Dear Committee members,

I am writing in support of a two-tiered system of rebate for psychologists whereby psychologists who have the necessary and specialised skills at a higher level than base level are able to attract higher level of rebates for those patients who require such highly specialised services.

Please see Appendix 1 for a clarification from Anthony M. Cichello regarding psychological specialities, training requirements and rebates.

Regarding my speciality, clinical psychology, I would again like to quote Anthony M. Cichello from the same communication: "Regarding our specialisation, we wish to re-state that Clinical Psychology requires a minimum of eight years' training and is the only profession, apart from Psychiatry, whose entire accredited and integrated postgraduate training is specifically in the field of lifespan and advanced evidence-based and scientifically-informed psychopathology, assessment, diagnosis, case formulation, psychotherapy, psychopharmacology, clinical evaluation and research across the full range of severity and complexity. We are well represented in high proportion amongst the innovators of evidence-based therapies, NH&MRC Panels, other mental health research bodies and within mental health clinical leadership positions."

My submission

I will provide you an insight into my training and practice as a clinical psychologist. I would like to outline firstly, my training, secondly my job history and finally examples of my clinical cases. I have summarised my cases for last week (beginning 26 July) to illustrate the range and severity of cases that I am currently treating.

It would be impossible to do the work I have been doing without the very comprehensive post-graduate training I received. I am not offering my example as constituting anything special about my caseload. I doubt I am atypical as a clinical psychologist in private practice in an inner city location. Many clinical psychologists, depending the locations serviced and their area of expertise, may have a much greater proportion of more severely disturbed patients including more personality disordered patients and those suffering from psychotic and neurological conditions.

### Clinical psychology training

My training took place in New Zealand. I did a three-year undergraduate degree including three years of psychology. I then did a Master of Arts (Clinical Psychology). This included both formal subjects at the university and two days a week attendance at a psychiatric hospital for practical training and supervision in psychometric and mental health assessment, psychopathology, diagnosis and interviewing. Watching experienced therapists working with patients behind a one-way mirror as well as being observed by supervisors was part of my weekly training. Placements included time on the acute admissions unit at the hospital. A research thesis, placements and attendance at seminars was required as part of the second year. I was then able to work as an Assistant Clinical Psychologist in the New Zealand mental health system. My third year of post-graduate clinical psychology training was very rigorous, involving a weekly seminar, supervision, including one-way screen work and close scrutiny of my reports and study program. My weekly self-study program usually involved 12 hours of reading, on top of my ongoing clinical job, and this was by no means excessive for people on that program. I then had to undergo an intensive two-day examination, in which I (and the only other candidate) was examined by two senior academic clinical psychologists. The exam program consisted of assessment of a patient behind the one-way screen followed by scrutiny of the written report of that assessment. Oral examination on all aspects of clinical psychology practice, including assessment, therapy, ethics took several hours. Scrutiny of the six extensive case reports submitted prior to the exam also took some hours. I passed the examination, providing me with a post-masters Diploma in Clinical Psychology and allowing me to call myself a clinical psychologist in the health system.

My continuing professional development, in the form of active skill building and reading, has included attendance at numerous workshops each year, conducted by national and international experts in the area of cognitive behavioural treatment of the disorders that I treat. I had no trouble meeting the level of required professional development when initially this was introduced by the Clinical College and later included as part of the Medicare requirements.

### **Work history**

From 1971, I worked in a New Zealand psychiatric hospital, one of the large institutions that was standard in Australasia at that time. I spent some years working in the acute admissions unit with patients whose diagnosis included schizophrenia, depression, bipolar disorder, severe anxiety and other conditions such as alcoholic and neurological problems. I was then posted to the inpatient alcoholism ward where I worked for three years. I was appointed to run an outpatient alcoholism clinic and referral service for the same hospital board that administers most public funded health organisations in an area under the New Zealand system. This centre provided both treatment referrals, education to the community and health professionals and prevention strategies and action. My duties included administration and planning but also participation in leadership in overseeing the addiction services for the area and liaison with national bodies in the field of prevention and treatment of addictions.

In 1983, I came to work in Melbourne having been offered a position in a private psychiatric hospital (The Melbourne Clinic). I was responsible for setting up and running an inpatient service with about 8 beds for patients requiring intensive cognitive behaviour therapy. Patient diagnoses typically included anxiety disorders, as well as depression and eating disorders.

After four years, I went to work part-time at a large public general hospital (The Austin) as a senior clinical psychologist, initially providing services to the Spinal Unit, then to general medical wards in addition to the psychiatric ward. My duties included teaching as well as the provision of therapy to patients, including some outpatients as well as education to patients and staff, and training of psychology graduates in clinical psychology.

In 1991, I moved to full-time private practice as a cognitive behavioural specialist with adults suffering (typically) from stress and anxiety, eating disorders and depression. For nine years, I chaired the VicHealth funded organisation Body Image and Health established for the prevention of eating disorders and the promotion of healthy body image and eating.

### **Cases from my last week of practice**

In the last week, I saw 25 patients in all. All of those are described below not including two who did not attend appointments. Patients were seen for one session only. Two medical practices and three psychiatrists have referred the large majority of these patients. I have not provided any material relating to outcome or the process of therapy as I wished to illustrate the complexity and severity of the conditions being treated.

Patient A: 53-year-old woman suffering from a severe grief reaction after the death of a close family member. History includes a disturbance in maternal attachment in her childhood and severe depression. Unable to work when depressed. Treatment: cognitive-behavioural based discussion with use of cognitive and behavioural strategies as needed.

Patient B: 47-year-old woman previously successfully treated for severe obsessive-compulsive disorder requested a session in order to deal with stress at work in order to minimise her anxiety reactions. She has been unable to contemplate making a job changes as is needed. Treatment: cognitive-behavioural based discussion and goal setting.

Patient C: 60-year-old woman with several serious stressors in her current life is attempting to minimise her anxiety attacks and stress-related vertigo. Treatment: cognitive-behavioural based discussion with use of cognitive and behavioural strategies as needed including scheduling of pleasant events.

Patient D: 44 year old woman recovering slowly from chronic fatigue syndrome is seeing me for a few sessions to provide psychological support following the loss of her job. Previously saw me when she developed a major depressive episode soon after the chronic fatigue was diagnosed and then treated with formal cognitive therapy and behavioural pacing strategies. Despite the exhaustion, she does need to make job applications. Present treatment: cognitive-behavioural based discussion with some behavioural strategies, including graduated and flexible goal-setting.

Patient E: 32-year-old man who has a history of panic attacks and currently suffers from severe depression with generalised anxiety symptoms. Treatment: education, panic management strategies, cognitive therapy with behavioural strategies including exposure to feared situations and feelings.

Patient F: 20-year-old student suffering severe social phobia with a history of being bullied at school. He has no social life and only one friend and has avoided getting a part-time job despite needing the money. Treatment: education, cognitive therapy and behavioural exposure.

Patient G: 44-year-old struggling with an emotionally deprived childhood. Despite significant professional success, she is extremely lonely. Wants to be able to form a loving relationship, for the first time, with someone who is emotionally available and unmarried. Treatment: Schema therapy for personality disorders which includes imaginal role-play, re-parenting strategies, cognitive therapy and behavioural exercise..

Patient H: 48-year-old woman previously treated with schema therapy education and cognitive therapy for a major depressive episode re-presented for a session following some marital discord. Her borderline traits make relationship problems especially troublesome. Treatment: schema based discussion with empathy and problem solving.

Patient I: 64-year-old woman who suffers from chronic dysphoria with previously significant anxiety and alcohol problems. She has no friends and does not much enjoy her husband or children. Has occasional sessions to monitor mood, thinking and activity. Treatment: cognitive-behavioural based discussion with use of cognitive and behavioural strategies to assist her in being more active socially and in scheduling more rewarding activities.

Patient J: 47-year-old woman previously treated for extremely severe depression has requested a few sessions to help manage her reactions to a problematic family situation. Aim is to prevent relapse. Treatment: cognitive-behavioural based discussion (previously received cognitive therapy) and behavioural strategies as needed.

Patient K: 62-year-old man who suffered acute panic attacks after the death of a close relative, fearing that he was having a second heart attack. Was anyway in the process of treating panic anxiety with significant avoidance. At this stage, unable to fly or use boats but now managing tunnels, exercise, heights and lifts. Treatment: education, panic management strategies, exposure tasks to deal with anxiety producing feelings and situations.

Patient L: 37 year old woman who suffered from a major depressive episode succeeded by dysphoria as she struggles to cope with one of her three children who has serious heart and lung damage requiring huge operations most years and is unlikely to survive to adulthood. Treatment: cognitive-behavioural based discussion with use of cognitive and behavioural strategies to contain anxiety.

Patient M: 48-year-old man referred for assistance in minimising his relapsing depression. he had left some jobs as a result and found it difficult and sometimes impossible to apply for other jobs. Treatment: cognitive therapy and behavioural strategies including role-plays. Currently he is having follow-up appoints to maintain progress and to plan and practice relapse management strategies.

Patient N: 41-year-old women referred for social anxiety with significant discomfort in social situations, mild depression and poor body image. Treated with formal cognitive therapy and behavioural strategies to increase social interaction and change self-critical behaviours towards her body.

Patient O: 62-year-old man with chronic dysphoria and severe longstanding personality problems has also a previous history of major depressive episodes. He is unable to complete a significant academic task and has been engaged in self-defeating behaviours for several years as part of this, precluding being able to work. Treatment: cognitive-behavioural based discussion with use of behavioural strategies including goal-setting.

Patient P: 25-year-old woman referred for treatment of anxiety and depression symptoms 18 months after a closed head injury. Treatment: education, panic management strategies, cognitive therapy, and behavioural assignments.

Patient Q: 55-year-old woman referred to assist in minimising relapse into depression. Has a history of severe depressive episodes requiring hospitalisation and ECT and also is highly perfectionistic. Unable to work currently in a paid position. Treatment: cognitive therapy and behavioural strategies to tackle avoidances, decrease perfectionism and unreasonable demands upon herself.

Patient R: 43-year-old woman presented with severe panic attacks and a major depressive episode following a very painful arm injury that was slow to heal. Treatment: education about anxiety, formal cognitive therapy, specific cognitive strategies to help manage panic and behavioural strategies to help manage anxious situations, including role-plays.

Patient S: 30-year-old woman referred for treatment of depression following the criminal conviction of her husband and the shame and secrecy around these circumstances. None of her family and friends know about this. Treatment: cognitive-behavioural based discussion at present with potential for cognitive therapy if needed.

Patient T: 57-year-old with extensive history of anorexia involving numerous lengthy hospitalisations now managing low-level chronic bulimia, gambling addiction suicidal feelings, low self-esteem and at present a re-emergence of her bi-polar disorder in a manic phase. Treatment: cognitive-behavioural based discussion with use of cognitive and behavioural strategies as needed.

Patient U: 47-year-old woman referred for a protracted grief reaction one year after the death of her father. She cried a lot at work and most of the weekend. Treatment: cognitive-behavioural based discussion with increasing emphasis now on behavioural strategies to broaden her social life.

Patient V: 31-year-old woman now finishing treatment for panic disorder complicated by abandonment problems and some minor obsessive-compulsive symptoms. Generally very anxious, she was angry with her parents for contributing for this problem and was unable to fly anywhere, which was required as part of her professional aspirations and as desired by her partner. Treatment: education plus cognitive-behavioural based discussion with use of cognitive and behavioural strategies, including practice flights and panic management strategies.

Patient W: 45-year-old woman with severe and complicated post-traumatic stress disorder, depression and suicidal ideation as a result of protracted and sadistic childhood sexual abuse. Treatment: some analytically based strategies plus cognitive and behavioural strategies. Regular psychiatrist involvement in supervision of this case with myself and the G.P.

Patient X: 36-year-old woman presenting for the first time. Has anxiety problems which exacerbate gastroenterological condition, complicated by comfort eating. Monitoring of the problems will help determine diagnosis and treatment plan.

Patient Y: 22-year-old woman who is finishing treatment following a major depressive episode secondary to being extremely stressed by inability to be assertive at work. Treatment: cognitive therapy, role-plays and behavioural assignments to be more assertive and less inhibited.

In summary, most of my patients are being treated for severe disorders that interfere significantly with their occupational, social, relationship and recreational lives. Some are patients who are managing better but have re-presented, perhaps only for one session, to get some help with current problems in order to maintain their psychological recovery.

I hope the examples given will help the committee understand the range and complexity of presentations that clinical psychologists such as myself are encountering. The sound post-graduate training in clinical psychology has enabled me to treat these people adequately but I could not do it without that. I could not do this work with a graduate level qualification in psychology.

I hope this is helpful and I wish you well in your deliberations.

Yours sincerely,

Lindsay Image