

Submission to the

Commonwealth Funding and Administration of Mental Health Services

Senate Inquiry: Community Affairs References Committee

26 July 2011

I would like to make a submission to the Senate Enquiry into the Commonwealth Funding and Administration of Mental Health Services. In particular, I would like to respond to the reduced number of sessions and the possible cessation of the two tiered payment system.

Number of Sessions

As a Clinical Psychologist my experience of working with clients is that presentations are often diverse and as a result, it takes two to three sessions to thoroughly assess and correctly formulate a client's case. It is this phase of treatment that directs therapy. However, psychological assessment is not occurring on its own during these initial sessions. Risks are also being assessed and a client's safety and support networks are ensured as a priority. At the same time, appropriate psychoeducation is being given to facilitate improved coping in these early phases of therapy. So, the initial two to three sessions of therapy may be very intense for the client but they are key to ensuring a client's safety and supports and in determining appropriate therapies are chosen for the next phase of therapy.

At the other end of therapy, it takes a couple of sessions to cover relapse prevention, reinforce psychoeducation and to ensure the client is generalizing treatment gains in their day-to-day functioning. Therefore, if we have only ten sessions (under the government's current proposal) in which to work with a client, there are relatively few sessions (say five to seven sessions at best) to perform the 'work of therapy' i.e., reach the client's therapy goal and to reinstate the client's functioning. It is insufficient, particularly when psychological difficulties have been long-standing and appear during periods of crisis/stress i.e., an acute phase. Further, other psychopathologies are more often than not comorbid with the presenting problems of a client. Finally, clients who are experiencing psychopathology in the acute phase will usually have poor insight and/or information processing (cognitive) difficulties as symptoms of their dysfunction, so sessions are often very simple i.e., 'less is more' when it comes to conveying the required therapy content to the client each session. Thus, progress is often slow, appropriate repetition is often required and it is a priority to go at the pace of the client, especially with Cognitive Behavioural Therapy. The current "number of sessions" model which supports a client with two groups of six sessions, plus the availability of a further six sessions for more complex cases, is not adequate for clients with a clinically significant Axis I disorder let alone more complex case presentations.

Further, to say that more complex cases should go on to public health services like community mental health services is convenient but unrealistic. I currently work in community mental health and we are overrun and there are not enough clinical psychology positions to help clients with these more complex case presentations.

Two-tiered funding

I would like to state that the Master of Clinical Psychology should be held out as the psychology profession's minimum benchmark of competence to deal with clients presenting with a clinically significant Axis I disorder. In fact, clinical psychologists should be encouraged and supported to go

on and complete their doctorates wherever possible, perhaps as an alternative path to full clinical endorsement.

Further, I note that through the course accreditation processes, the Australian Federal Government already differentiates a four year full-time undergraduate psychology degree from a two year full-time postgraduate degree in both its breadth and depth of content across Australian universities. The additional two years of full-time university study to attain the Masters of Psychology, Clinical Psychology, also includes a minimum of 1,000 hours of supervised specific clinical practice as well as weekly professional practice seminars throughout the two years of additional study. These professional practice seminars provide group supervision of actual cases that are presented by students and/or academic staff wherein case formulations, interventions and case management planning is discussed.

Once the masters is successfully completed and full registration gained, a clinical psychology registrar must then go on and complete two years of full time clinical psychology work with an authorized specialist clinical supervisor and pass further examinations in order to become endorsed as a full Clinical Psychologist and thus use the title "Clinical Psychologist".

These additional years of study, clinical supervision and commitment (four to five years full-time in total over and above a four year undergraduate degree by comparison) cannot be compared with a '4 + 2' trained psychologist wherein that person undertakes two years of supervised work which is not in a clinical setting because clinical psychology placements are reserved for those undertaking their Masters of Psychology, Clinical Psychology.

In my own experience, there is a big difference in focus between an undergraduate psychology course and the Masters of Psychology, Clinical Masters course I completed. Such a course may be specifically reviewed by checking the course accreditation guidelines for Masters of Psychology, Clinical Psychology degrees.

Yours sincerely,
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Kind regards,
Jan Gregory.