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I am a Clinical Psychologist. I have a Bachelor of Science, Graduate Diploma of Counselling Psychology and a Doctor of Psychology. I also have a Diploma of Business. I am a member of the Clinical College of the Australian Psychological Society and am registered as eligible to provide supervision for psychologists under the national registration requirements. I have been practicing psychology for almost 20 years and work with infants, children, adolescents, families, couples and individual adults where there is a mental health problem. I follow the scientist practitioner approach of conducting an assessment and then implementing an evidence-based treatment based on the diagnostic formulation that is the outcome of the assessment.

What follows is my submission to the Senate inquiry into Commonwealth funding and administration of mental health services. My submission relates to the following terms of reference:

B: changes to the Better Access Initiative including:

- i) The rationalization of allied health treatment sessions
- ii) 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;

C: the impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services Program:

D: services available for people with severe mental illness and the coordination of those services;

E: mental health workforce issues, including:

- i) The two-tiered Medicare rebate system for psychologists
- ii) Workforce qualifications and training of psychologists.

F: the adequacy of mental health funding and services for disadvantaged groups.

B: changes to the Better Access Initiative including:

- i) The rationalization of allied health treatment sessions*

I provide Psychological Therapy under the Better Access to Mental Health program. Of the clients I have seen since it began 27% required 10-18 sessions and 23% required more than 18 sessions. Therefore half of my clients require 10 sessions or more. Of those who have required more than 18 sessions the limitations to the subsidy has meant that some people have reduced the frequency of their sessions, while others' treatment has crossed over into a new financial year and they have been eligible for another referral.

I have grave concerns for my clients if the number of sessions is limited to a maximum of 10. So much so that I am reconsidering whether I will continue to provide services under this scheme if the cuts go ahead. My concerns are two-

fold. Firstly, a prescription of treatment length that is not associated to diagnosis or presentation defies all evidence of good clinical practice. Secondly it has no capacity for changes in people's lives that impact on their difficulties. For example, one of my clients was in treatment for a severe anxiety disorder. He had frequent panic attacks and had recently had a breakdown at work and was unable to work for a period of time. After 11 sessions he made considerable progress and we discussed reducing the frequency of his sessions. At this crucial point in his recovery his father died suddenly and unexpectedly. He was eligible for a further six sessions under the Extreme Circumstances criteria, but if I had seen him in 2012 then this would not have been possible.

ii) 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.

The system currently relies upon a GP assessing whether there is a mental health illness and the severity of such. This is a major flaw. I have studied at university for seven years and after that training have had more than ten years of regular supervision and peer consultation, as well as continued professional development in the area of complex mental health presentations and treatment. In my experience the assessment of mental illness is complex, and often new information is discovered as a therapeutic relationship is established. It would be very difficult for a GP, a non-specialist in mental health, to determine with a high degree of accuracy the presence and severity of mental illness. The variation in the level of understanding of GPs of mental illness is reflected in the referrals I have received.

It would make more sense to have a client see a psychologist in the first instance for the assessment and then return to the GP, if GPs are required to have an ongoing administrative role. This process would result in increased commitment on behalf of clients and reduce GP sessions for item 2170 that do not result in psychological treatment.

C. The impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services Program.

This program has thus far made no impact on my work- I am not aware of how it works or how to refer clients to it. It does not register for discussion in my professional network. I also work part time in public pediatric mental health and am active in a number of different professional arenas. As such I believe my lack of awareness of the program despite my active stance in the profession is a reflection of the impact and adequacy of services provided to people with mental illness through this program.

D. Services available for people with severe mental illness and the coordination of those services.

As a Clinical Psychologist a reasonable proportion of my practice is with clients who have a severe mental illness. I find that coordinating with Adult Mental Health Services and/or private psychiatrists relatively straightforward, notwithstanding the usual difficulties of achieving contact between mutually busy people. However, it is at the end of the time limited nature of my intervention that there is major concern as there are very few ongoing referral options, and for those that do exist there is a long waiting list, leading to a gap in treatment for the client. This situation is counter-therapeutic for the client to say the least.

E. Mental health workforce issues, including:

i) The two-tiered Medicare rebate system for psychologists

It is important to bear in mind that Focused Psychological Strategies are a different intervention than Psychological Therapy. They apply to different client presentations and require different levels of skill and training. They also expect different outcomes: Focused Psychological Strategies aim at helping clients manage their symptoms whereas Psychological Treatment aims at a cure.

The evaluation of the Better Access to Mental Health Scheme had a number of major methodological issues that must be addressed in order. Major limitations of study were that it comprised a self-selected sample of clients, and that it did not compare the nature, diagnosis, or complexity of presentation, nor outcome of intervention by type of intervention offered (Focused Psychological Strategies or Psychological Therapy). These methodological flaws mean that the results cannot be generalized to the whole Better Access To Mental Health Program.

ii) Workforce qualifications and training of psychologists.

In my experience of working with Psychologists in both the public and private sector I have found a vast difference in the Psychologists trained via the apprentice model and those who have Masters and Doctoral level university training. I am a Registered Supervisor and no longer take on supervisees who are not Masters or Doctoral level trained because their foundation is not sufficient for the complexity of modern psychological practice and the daily collegial support is extremely limited. I know senior colleagues who were trained via this route many years ago who describe a system very different to that available now, with significant support and daily supervision. This is not the case now and I believe it is unfair on Psychologists and their clients to expect to learn the complexity of Psychological Practice without the rigor of Masters or Doctoral training.

F. The adequacy of mental health funding and services for disadvantaged groups.

The disadvantaged group I would like to address is those under the age of 18 years. The Better Access to Mental Health initiative is based on an individual adult model and fits poorly for children. Best practice in child mental health is to see parents and children separately in many cases. At the very least standard

child mental health practice is to see parents at least once or twice without the child present. The Better Access to Mental Health initiative requires the index patient to be in the room to allow the rebate. This is inappropriate and unfair for children. For example, I often find that parent-only sessions reveal significant discord in the marital relationship that clearly impacts on the child's mental health, but is not appropriate to be fully discussed in their presence. Some GPs have enabled this work to take place by referring the parent under their own Mental Health Care Plan, but this practice then limits the parents' capacity to seek treatment for any individual difficulties they might have if their limited sessions are used for helping the treatment of their child.

Conclusion

It is vitally important that people in need of Psychological Therapy are able to access treatment for as long as required. Clinical Psychologists are well trained in the diagnosis and treatment of mental illness and have a rigorous professional development process in place. Clinical Psychologists are trained in the scientist-practitioner approach to follow an appropriate hypothesis-testing assessment and then implement an evidence-based treatment. In this way they are very well placed to provide Psychological Therapy in the way that psychiatrists were once more able to before their numbers dwindled and the patient population increased.

Focused Psychological Strategies are a valuable intervention for some patients. However, it is a mistake to compare Focused Psychological Strategies and Psychological Therapy as if they were the same.

Finally, it would be a pity to limit psychotically services, which are required to follow a rigorous evidence-base, based on results from one methodologically compromised study.