

To Members of the Senate Community Affairs Committee

As a Clinical Psychologist I am writing to express my deep concerns about the proposed changes to the Mental Health Services that relate to changes in the Better Access Initiative and the mental health workforce issues.

Terms of Reference

The two terms of reference that are of particular concern are:

- (b) (iv) the impact of changes to the number of allied mental health treatment services for patients with mild or moderate mental illness under the Mental Benefits Schedule
- (e) (i) the two-tiered Medicare rebate system for psychologists

Assumptions

It would appear that proposed changes are based on the following assumptions, namely that:

- all patients presenting to psychologists can be classified as having **mild** or **moderate** mental illness
- the extra training and level of on-going Professional Development to maintain the classification of a Clinical Psychologist, as opposed to a General Psychologist, has no bearing on assessment and outcome of treatment.
- Clinical Psychologists do not have adequate expertise to treat **severe** cases
- The Better Access Evaluation was a piece of sound research, the results of which apply directly to these two terms of reference.

Challenges to the assumptions

1. The range of patients presenting for treatment include those experiencing single simple phobias to patients with complex anxiety and depression, the causes of which can be deep-seated and can include such things as past trauma, dysfunction family of origin, personality disorders and psychiatric disorder. Clinical Psychologists have the ability to complete a thorough assessment and to make a differential diagnosis.

2. The extra training associated with Clinical Psychology involves the teaching of sophisticated psychological concepts. Without such training therapists do not have the ability to assess the contribution of complex factors involved in the emergence of mental illness problems. This is essential for a differential diagnosis of mental illness and the formulation of a treatment plan. Clinical Psychologists have the ability to select from a range of approaches and to systematically evaluate the effectiveness of treatment so that it can be adapted throughout to ensure that therapy is individually tailored to the needs of the patient.

3. Lack of recognition of expertise of specialist, rather than generalist, skills does not occur in other disciplines, particularly within the medical field. While General Practitioners can prescribe anti-depressants it is not assumed that they provide the same level of treatment and expertise as Psychiatrists. It should also be noted that the difference in expertise is also remunerated accordingly.

4. Best practice worldwide discriminates between Clinical and General Psychologists. To get rid of the two tiered system would be to place Australia out of step internationally and in particular with Britain and the United States. It should also be noted that even within Australia this issue has previously been heard by the Full Bench Hearing of the Industrial Relations

Commission in Western Australia in 2001. Remuneration was pegged according to differences in definitions of different levels of expertise of Clinical and General Psychologists. Level 1 included supportive counselling and simple techniques, Level 2 circumscribed psychological activities as described by protocols, and Level 3 was associated with deep-rooted underlying influences that required a discretionary capacity to draw on a multiple theoretical base in order to develop individually tailored programs. General Psychologists were seen as appropriate therapists to undertake the first two levels but it was decided that only Clinical Psychologists should undertake the therapy required for Level 3 and that they should be remunerated accordingly.

5. A reduction in the current number of sessions available through the scheme may be appropriate for simple cases, however, this idea again fails to recognize the needs of patients with complex problems, and these patients are currently seen within the scheme. In fact, rather than a reduction of sessions, severe cases would benefit from an increase in the 6 + 6 sessions with an extra six for extraordinary cases as it stands currently.

The proposal that patients with more severe mental illness should be assessed by a Psychiatrist after 6 + 4 sessions will cause a disruption to, and often a duplication of treatment approaches. The waiting time to see a Psychiatrist can be considerable leaving the patient without psychological input, causing their condition to worsen. The impact for the patient who has started therapy with one therapist and then has to change therapists has not been considered. For someone with a history of trauma who first has to build trust with the therapist and then has to re-iterate their story all over again, it is obviously likely to be considerable. This is also likely to be the case for patients with other complex conditions as well.

Furthermore, the proposal of reduced hours fails to recognize the diagnostic and therapeutic skills of Clinical Psychologists. Like Psychiatry, for Clinical Psychologist courses to be accredited they must include training specifically in the field of lifespan and advanced evidence-based psychopathology, assessment, diagnosis, case formulation, psychotherapy, evaluation and research across the full range of severity and complexity of cases.

6. The gap between Medicare funding and the cost of seeing a Clinical Psychologist will widen. This has the potential for more serious cases to be either referred to those without adequate training in assessment, diagnosis and treatment formulation, or the individual must find that money which can create financial hardship.

7. The conclusion that the outcomes for Clinical and General Psychologist are the same has been based on a piece of methodologically flawed research. The nature, diagnosis or complexity of clients, nor the type of intervention offered was not identified and so it was not possible to conclude that the outcome for both groups of therapists was the same, and yet this appears to have been the conclusion drawn.

In addition, the sample was based on self-selected psychologists who then selected patients to be included as subjects and the research questions were administered in the session. All of these factors are likely to bias the results in favour of positive outcomes for all, irrespective of the type of psychologist offering the service. A well-designed prospective study aimed at answering specific questions in accordance with the principles of sound psychological research is needed, before conclusions are drawn.

I hope that you will give these concerns the consideration I believe they deserve as you review the scheme and the role Psychologists play within it.