

## **Senate Community Affairs Reference Committee inquiry into Commonwealth Funding and Administration of Mental Health Services**

I like to address two points in my submission: the two-tier system to Medicare rebate for psychological services and the Medicare cutback to the number of sessions available for psychological services.

### **Two-tier system to Medicare rebate for psychological services**

I am writing about the two-tier system of the Medicare Rebate for psychological services and I am advocating for the continuation of the two-tier approach for psychological services.

Reasons:

#### Clinical Psychologist as a specialist training

Clinical psychology is a specialist training involving two years post-graduate tertiary training plus two years clinical supervision before endorsement of specialisation. Training in clinical psychology specifically focus on assessment, diagnosis, case formulation and service delivery to the population with mental health problems and emotional disturbance. Entry to such tertiary training is highly competitive and highly selective ensuring high quality graduates to deliver high level of service delivery to the focus groups. In contrast, a generalist undergraduate degree in psychology provides a general training for working in the area of psychology. It provides the essential foundation for further specialisation and training in areas such as research and academia, educational psychology, organization psychology, forensic psychology, clinical psychology etc. A generalist undergraduate degree does not provide specialist training in the area of mental health and emotional and behavioural problems.

Personal perspective – I worked as a generalist psychologist for more than 15 years before embarking on my post-graduate clinical training. During these 15 years I was fortunate enough to gain vast experience and supervision by others within the government departments as well as continued other non-tertiary training to augment my generalist degree. I was of the opinion that my other training and work experience would be equal to those with clinical training. After I have completed my post-graduate training in subsequent years, I realised that I have gained significant diagnostic and assessment skills as a result. Furthermore, post-graduate training expanded and developed my critical thinking that now forms the foundation of my clinical assessments, service deliveries and evaluation. From a personal point of view, these are crucial differences between a specialist and a generalist degree even for a previously experienced and well-seasoned practitioner.

Clinical perspective – I like to use the following case to illustrate the subtlety in assessment and treatment that result from clinical training. A 60 years old woman presented to me with depression and marital problems. She blamed much of her depression on her marriage. She previously saw a generalist psychologist for many sessions and the psychologist focused on problems within her marriage. After several sessions he terminated psychological treatment and

declared her as “recovered” as she felt better after discussing issues in her marriage. She subsequently presented to me with her depression still present, as well as continued marital difficulties. Her medical referral was for her depression but I noticed that she was on Ritalin. Further probes revealed that she was diagnosed with Attention Deficit Hyperactive Disorder (ADHD) by her psychiatrist. Depression is a co-morbid condition with ADHD as ADHD patients need high levels of stimulations in order that they become focus and engaged with life. They become unfocused and depressed with normal level of stimulation that comes with normal everyday life. Her perception of marital difficulties was confounded by her depression that arose from inadequate level of stimulation in her day-to-day life. The more likely scenario is her depression associated with her ADHD was affecting her perception of difficulties within her marriage. As I was trained in diagnosis of mental health problems I was able to recognize the effect of ADHD and its co-morbid conditions and their impact on sufferers of these conditions, and this was missed by the generalist psychologist. Unfortunately, many of such cases exist.

Professional perspective – I am constantly being approached by generalist psychologists seeking assistance and supervision for mental health diagnoses, psychometric assessments, case formulations and report writing. It seems like they have not adequate training in these areas, which are essential skills needed to work in the mental health area.

#### International standard

Around the world in countries such as USA, UK, Canada, etc., the minimum qualification for a psychologist working in the clinical area is a post-graduate degree in clinical psychology, and often at a doctoral level. There is no provision in the work force for a generalist psychologist with an undergraduate degree to be employed as a psychologist in these countries. They may use their undergraduate degree to work in other areas but not as a psychologist working in the clinical area. Australia lags behind in terms of increasing the minimum standard of training for psychologist to a post-graduate level. The two-tier rebate system from Medicare goes some way to address and endorse this issue of specialist training and it is important that this system remains. If the two-tier system is reduced to a one-tier system in favour of the generalist psychology the implication of this has far-reaching consequences beyond that of cost-savings for the government. It will be a retrograde step for psychology as a profession in Australia on the international level if its government does not endorse the distinction between generalist and specialist psychologists through the operation of one of its major entity such as Medicare.

#### **Medicare Rebate Cutback for Psychological Services**

I like to congratulate the government for increasing funding to the mental health area. I also understand that the Senate Committee is mandated to reduce cost of funding to Allied Health Professionals. The Budget of 2011 has reduced the number of psychological services available for each person from 18 to 10 sessions per calendar year. This is apparently based on data received by

Medicare that shows a low percentage of users of psychological services needing 18 sessions.

Despite the low usage of 18 sessions indicated by Medicare data by the population with mental health issues, it is important this number of sessions is available to a part of this population that requires it. I am referring to the portion of this population who has severe level of mental health problems but not require hospitalisation or institutionalisation. This population consists of people with complex and multiple mental health problems such as but not confined to: having complex Post-traumatic Stress Disorder with depression arising from many years of suffering from child abuse (emotional, physical and or sexual), or long term drug and alcohol abuse with depression, etc.; or they have an Axis II diagnosis which means they have a personality disorder of some description. The very diagnoses of the latter are predicated on the enduring and chronic nature of their personality traits that are highly dysfunctional. Individuals with personality disorders are often those who have high usage of other expensive medical interventions, like presenting to the emergency department of the hospitals or being hospitalised for some fictitious illnesses, or threatening suicide and involving expensive tertiary intervention teams all for the purpose of attention-seeking. These individuals and those with multiple problems cannot be adequately managed by 7 - 10 sessions of psychological interventions due to the complex and severe nature of their conditions. Yet if left unchecked, they would utilise hospital beds and demand medical treatment that would be more expensive than granting them a few more psychological sessions to help them manage/contain their conditions.

In my experience, this population do make significant improvements but they need more input and over a longer period than those with a singular problem/diagnosis.

Given data from Medicare shows a low usage of 18 sessions, why not leave it as it is so that those who need it can access it. Reducing the number of available sessions from 18 to 10 will not only cut out services for those who need it but will make no difference to those who will only use 7 to 10 sessions per year regardless of whether there are 10 or 18 sessions available.

#### Proposal

Given that the Senate Inquiry is mandated to reduce cost, one option is to cut the number of psychological sessions available to the generalist psychologists from 18 to 10 sessions per calendar year, and retain 18 sessions per calendar year as available through Clinical psychologists for treatment of those who need the specialist input.