

Commonwealth Funding and Administration of Mental Health Services

I write with regard to the inquiry into the Government's funding and administration of mental health services in Australia. Following the terms of reference for the inquiry, I wish to comment on the following items:

The Government's 2011-12 Budget changes relating to mental health with particular reference to changes to the Better Access Initiative (reference: a&b)

I would firstly like to convey my disappointment and concern of Medicare cuts to the services of Psychologists under the Better Access Scheme. I work in public mental health so do not work in private practice or with the Better Access Scheme personally, however I believe that these new budget cuts will have a detrimental effect on many sufferers of mental health issues.

I have worked in the public system for the past 10 years and over time, the public system has reduced services to those individuals with illnesses such as Depression, Anxiety, PTSD, Personality and stress issues as they are not seen as our 'core business' and so do not fit into our entry criteria. The public system does a wonderful job but now focuses much of its services on chronic mental illnesses such as Schizophrenia, Bipolar Disorders and those who are acutely suicidal and refers most other issues described above to private Psychologists. All of the problems that individuals face are extremely important issues because I have seen the distress they can cause, but I worry that if our ability to refer to private Psychologists is limited then who will be available to sufficiently treat those people with often a variety of complex issues? It should not be underestimated the distress caused by someone perhaps suffering from Depression, Anxiety, domestic violence issues, PTSD, personality issues, family and financial/work stresses - it is also the case that these issues are often not seen in isolation but a co-morbid presentation.

I realise that the new Medicare budget allows for up to 10 sessions which for some people will be sufficient. However for many people that I have worked with who suffer from life long struggles and whose issues are entrenched in a long system of family problems, this will not nearly be enough and it will often be more detrimental and unethical to open up some issues without sufficient time to treat. I would also like to raise the importance of continuity of care, as it can be difficult for clients to develop rapport with someone they do not know especially when there are very sensitive issues involved. I wonder what options a person has when they have exhausted their 10 sessions – wait until the next year without treatment, attempt treatment in public mental health or access sessions available to Psychiatrists which are most often very costly. None of these options are acceptable, as it does not resolve the issue of better access or continuity of care nor does it address treatment issues.

The impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program (reference: c)

I write with the hope that we could provide a service which meets the needs of all people, rather than disadvantaging any particular client groups which is what I believe will result from these budget cuts. It has been said by some that those who see private psychologists constitute the 'worried well' or psychologists only work with Depression and Anxiety. I know for a fact this is simply not the case, as described above in the complexity of individuals who are referred and present for treatment. Many clients who have utilised the

without being caught up in bureaucracy of the public system. For many individuals in the community, mental health concerns continue to be stigmatised so the Better Access Scheme has also encouraged these people to access treatment when they may not have sought assistance. It appears we have made significant progress in the area of mental health access over the past few years and it would be a shame to regress and see a number of people without access to an appropriate and efficient service.

Mental health workforce issues (reference: e)

Clinical Psychology is a specialised field where education and training aims to integrate scientific and professional knowledge and skills, that focuses specifically on the assessment, formulation and treatment of complex psychological difficulties (Society of Clinical Psychology, APA). To remove the two-tier system would result in negative impact on clients and would fail to recognise the advanced skills and expertise acquired through additional training. For instance one cannot claim that a Psychiatry Consultant is the same as a GP specialist or even a Psychiatry Registrar.

I hold a senior role in my current position and a major proportion of my job involves clinical supervision, monitoring the standard of clinical skills and recruitment of Psychology staff. While I have no wish to offend my General Psychologist colleagues, in my experience there is a clear relationship between the training and level of skill of Psychologists that gained registration via the 4+2 pathway (Generalist) and those who underwent postgraduate clinical training (Specialist). This is certainly not a global observation as there are many General Psychologists that are extremely proficient in their work but I believe there is a lack of standardised training and assessment processes via the 4+2 pathway, as gaining registration in this way depends on the Provisional Psychologist working under the supervision of often only one or two supervisors whose own skill level may not have been adequately assessed.

Conversely Postgraduate Psychologists have been formally assessed via coursework, completion of research project and their experience at various internal and external placements with communication between supervisors and the university. The Postgraduate Psychologist then requires further clinical supervision on the job to be eligible for Clinical College membership – this equates to a minimum 4 years of training and supervision post one's undergraduate degree to become a clinical member. This method offers a standardised process for measuring clinical competency and maintaining clinical standards.

It has also been mentioned that it is 'impossible' for Generalist Psychologists to gain membership to the APS College of Clinical Psychology. I can attest that this is not the case as I personally have staff members undertaking individual bridging plans to complete this process successfully.

Like all 4th year graduates, I was once faced with a choice about how to develop my career. I personally completed a Postgraduate degree in Clinical Psychology, which required an additional 3 years of postgraduate study after my 4 year undergraduate degree and then a further 2 years of supervised practice to become a member of the APS College of Clinical Psychologists. I feel that I would simply not have been equipped to adequately work at a similar standard had I not undertaken this path.

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