Submission to the **Inquiry: Commonwealth Funding and Administration of Mental Health Services**

I am a clinically trained psychologist who has a private practice in the Inner West of Sydney and I would like to make a submission in reference to the inquiry of Commonwealth Funding and Administration of Mental Health Services. I would like to make my submission in regards to several sections of the terms of reference but particularly to the sections regarding the two-tiered Medicare rebate system for psychologists (e (i)) and the rationalisation of allied health treatment sessions (b (ii)).

I have practised as a Registered Psychologist for 1.5 years Post (Clinical) Masters. After attempting the 4+2 pathway I became aware that although I was gaining extensive external training in many things I lacked an integrated approach to my work and a deeper knowledge of psychopathology that is required when dealing with the severest end of mental health. The Clinical Masters' degree lived up to my expectations in every way and provided me with the skills, knowledge and integrated approach to my therapy work with moderate to severe psychopathology that I believe improved my service to clients exponentially.

My practice employs both Clinical and Generalist Psychologists. I have been able to notice a large difference between the work of my generalist colleagues and that of myself and other psychologists who have had the Master's Clinical Training. It is a striking difference which comes across both in feedback from clients regarding the service they have received from the Practice and also in Peer Reviews involving the Generalist and Clinical Psychologists together.

Clinical Psychology is the only specialisation that provides a mental health clinician with the most detailed skills in assessment, intervention, research and formulation that is necessary for psychopathology at its severest levels. The level of expertise specifically related to mental health treatment, prevention and research provided in this higher degree is equivalent to that of the psychiatry specialisation in medicine. I believe that clinical psychologists need to be rebated at the different level to recognise this level of specialisation that is automatically given to specialisations in other areas of health and mental health and that the value clinical psychologists provide in terms of effective, evidence based treatment is second to none.

It is a principle of the Masters of Clinical Psychology training programs in Australia that students are taught the scientist-practitioner model which allows clinical psychologists to evaluate their treatment models according to the evidence in the literature and the clinical evidence they have, to inform their treatment of patients in a way that other mental health clinicians are not taught or obliged to do. Clinical Psychologists have the capability of being flexible in their treatment response and to tailor their intervention to individual patients and continually question and evaluate their treatment and make the changes necessary to achieve an optimum outcome. The original recognition of the specific skills of Clinical Psychologists should not be now reversed when intervention for people with a mental illness is more critical than ever.

Section b(ii) of the terms of reference refer to the rationalisation of allied health treatments in the federal budget this year.

Working as a Clinical Psychologist in a practice that engages conscientiously with the GPs in the local area, I am privileged to work with clients who often have longstanding and severe forms of mental illness. I refer not necessarily to those with psychosis who are often held up as the mentally ill, but those with severe forms of depression, personality disorder and anxiety disorders. Often my clients have lived with their mental illness for many years prior to seeking treatment and often they have been enabled to seek treatment due to the Better Access Initiative as they otherwise would be unable to afford treatment. This Initiative has in my opinion helped people to access treatments who would otherwise never have accessed treatment and who do not qualify for on-going case management in our public mental health services. In the inner western suburbs of Sydney mental health services only provide case management and ongoing intervention to those with severe psychotic disorders and to all others only crisis intervention is provided, thus most severe mental health is invisible to the system and the Better Access Initiative finally provided these patients with access to affordable, quality, effective, evidence based treatment by psychologists. It also meant that they could receive multidisciplinary care with GP's and psychiatrists jointly with psychologists that was streamlined and communicative. I have personally seen the improved functioning and resolution of long term issues in literally hundreds of patients since the commencement of the Initiative and I am proud to say that I work effectively with local practitioners (including psychiatrists) to speed my clients to recovery. It is the treatment of these broader disorders (who make up the bulk of mental health) who will help us to stem the overwhelming problem of mental health in our community rather than the emphasis on psychosis whose prevalence is extremely low. The amount of sessions provided by the government under the Medicare rebate was modest when it was 12 (with six extra in exceptional circumstance). It was never enough for those with more severe forms of disorder but it was a start. For many these 12 sessions were all they needed and for some it was a drop in the ocean to address the problems they presented with. These sessions have now dropped to ten (with no option of further sessions where circumstances change) and some issues arise when these sessions start to drop.

In order to work in an evidence-based manner Clinical Psychologists work on the basis of making detailed assessment and formulation prior to starting treatment. This often takes at least two sessions and in the case of children and families where assessment is more complex or involves more people this may be more. This then only leaves a handful of sessions in which to administer treatment and often leaves the psychologist in the dilemma of whether to commence a treatment which may not be able to be completed in the amount of sessions remaining where the client can clearly not afford further treatment beyond the rebated sessions. I understand that there are other opportunities for accessing treatment becoming available through the ATAPS system however the specificity of these programs means that the majority of the clients I mentioned above will not qualify or the Medicare local may choose to spend the funds on specific populations again excluding the groups that may in fact have the most benefit from treatment. I urge the committee to consider that this reduction in sessions is highly detrimental to the clients who suffer from the most prevalent disorders as well as the most severe.

I also find in my practice that patients presenting with complex presentation including depression, anxiety and post –traumatic stress disorder do not present to our public system unless they are in a suicidal or self-harm cycle and yet their illnesses and difficulties have a large effect on our community. It is unrealistic to achieve the goals of health for these patients in 10 sessions and yet we know that in 30 sessions we can improve their function significantly! It is not that these patients can't get better but that they need longer to do it. It is my belief that clinical psychologists are best placed to treat these disorders effectively and efficiently. It is psychology that has provided the evidence based treatments that work in reducing the mental health burden in our community; however they need the support of the government in the form of adequate rebated sessions in order to deliver these treatments to the people that need it most.

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.

The proposed changes to the Clinical Psychology rebate in effect punish those that have made the significant and cumbersome extra financial and personal sacrifices for those extra years in the same way as if a qualified medical specialist e.g. a Neurosurgeon would suddenly be given the same renumeration as a G.P. As a Neurosurgeon s/he has extra responsibilities and additional costs of extra research, extra equipment, lengthy assessment and treatment tools and procedures etc. That a G.P. does not have. This is in addition to the initial personal and financial sacrifice associated with the extra years of study and extra qualification which s/he will now not get renumerated for, the Neurosurgeon now also has the additional new extra expenses/sacrifices which come from extra knowledge and extra responsibility which do not apply to a G.P. and which s/he will not be renumerated for. Furthermore, the Neurosurgeon can not simply opt to not use these i.e. let these extra knowledge, procedures, tools and responsibilities fall by the wayside and use G.P. tools and procedures as an alternative; as this would be unethical, not in the best interests of the client and possibly also impractical as their practice is not set up for G.P. level assessment and treatment.

In any case, if it did happen, by some accident in the senate, that a Neurosurgeon became equivalent to a G.P. in terms of service delivery, who would you rather send your mother/ father/ son/daughter to assess and treat a cranial abnormality? And what if the Neurosurgeons could no longer afford to keep their practice open and had diverted their energies into academia or elsewhere? What would you do?

M.Psych (Clinical)