Senate Community Affairs Reference Committee

(a) The Government's 2011-12 Budget changes relating to mental health:
As a Clinical Psychologist I am deeply concerned about the government's proposed budget cuts to the Better Access scheme. Specifically, I believe that reducing the number of sessions that would be available to patients from 18 to 10 per year will leave a considerable proportion of patients who are in need of assistance left without appropriate access to mental health care.

I work in a private practice with a group of Clinical Psychologists within a regional setting. The practice is based in a low socioeconomic demographic area and we routinely provide bulk-billing services to all of our patients. The individuals I treat under the GP Mental Health Care plans present with complex and chronic issues, and a considerable proportion of the population I see suffer from moderate to severe levels of impairment in functioning. I strongly object to notions of the scheme delivering superfluous services to the so-called "worried well".

In my experience, the vast majority of patients who are referred to me are in genuine need of help. A cut to the number of sessions that would be available to patients, would leave many under-treated. I question the ethical practice of opening up an individual's wounds only to leave them exposed and untreated, without offering affordable therapy. Best practice research evidence clearly suggests that 10 sessions would be generally insufficient in adequately treating many of the issues that are commonly seen in patients under the Better Access scheme, such as Post-Traumatic Stress Disorder and Major Depressive Disorder. Furthermore, the proposed number of sessions offered under the scheme would be insufficient in treating the significant percentage of patients who present with co-morbid issues.

The suggestion that patients currently seen under the Better Access scheme would be able to receive adequate provision of mental health services by seeing a Psychiatrist is highly questionable. Firstly, Psychiatrists like many other medical specialists, are scarce in numbers and already have long waiting lists. Secondly, the role of a Psychologist and a Psychiatrist are vastly different. The services provided by the respective professions are not interchangeable. I also question how it is any more cost-effective for a patient to access services under a Psychiatrist compared to a Psychologist. The other suggestion that mental health services could be better utilised if redirected under the ATAPS stream is also dubious. I believe that many patients would fall in between the cracks of the two separate systems of mental health care. The key difference between the Better Access and ATAPS schemes from the point of view of accessing psychology services is that the latter scheme has an added level of bureaucracy. Rather than the GP directly liaising with the Psychologist, referrals under the ATAPS scheme are coordinated through Medicare Locals or divisions of general practice through an administrative process. What I seriously question is how this alternative pathway can possibly provide a more accessible service. Also, how does a redirection of funding to the ATAPS scheme allow Psychologists and General Practitioners to better align the demands of clinical needs with service provision?

I encourage the government to reconsider its position on reducing the number of sessions. If the evaluations so far suggest that the scheme is effective and that only a

small proportion of referred patients need more than 10 sessions, why not allow the Psychologists, GPs, and patients who are best informed about what the clinical needs may be, to determine what the appropriate number of sessions should be?

(e) Mental health workforce issues:
I am also writing in relation to the proposed changes to the Medicare two-tier system for rebating General and Clinical Psychologists. I am particularly concerned about the proposition of dismantling the distinction and therefore eliminating Clinical Psychology as an area of specialisation. I am aware that as a Clinical Psychologist who provides services under the Medicare scheme, it is inevitable that any attempt to defend the status quo may be seen as self-serving. I was however at one stage an Honours graduate who faced a choice about what pathway to earn registration as a Psychologist. During that time, I faced the choice of seeking my registration through either entering into a two-year supervised practice plan or continuing on with further study. There were many good reasons to opt for the former option, as the time taken to complete registration would have been shorter and the process less intensive.

Compared to juggling the demands of conducting research, completing coursework, and gaining crucial clinical experience through internship and externship placements in a variety of mental health settings, obtaining registration under the supervised practice pathway would have been a lot less challenging and more cost effective. I was however motivated to develop advanced clinical skills and understood that the required level of training to meet this goal could not be provided by merely receiving supervision in a single setting. I therefore made a decision to embark on an additional three-years of full-time study involved in completing a Clinical Doctorate. Compared to the four plus two pathway for attaining registration as a General Psychologist, post-graduate clinical programs offer a more standardised and rigorous training process in the areas of psychopathology, assessment and evidence-based therapies. In addition, the post-graduate training model offers a more intensive supervision and assessment process for measuring clinician competency. Whilst many General Psychologists are exceptionally competent, the pathway for becoming a Clinical Psychologist offers a more reliable method for ensuring that clinicians have met advanced clinical competencies.

Whilst I believe that there needs to be a minimum level of post-graduate training in order to specialise in Clinical Psychology, it is also important to maintain an ongoing involvement in professional development. The clinical college requires their members to pursue professional development opportunities beyond what is required for General Psychologists. I therefore believe that the current two-tier system appropriately recognises the distinction between the different levels of training, demonstrated competency levels and ongoing professional development demands between General and Clinical Psychologists.

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