Community Affairs, Committee (SEN)

Senate Inquiry – Commonwealth Funding and Administration of Mental Health Services

I would like to make comment around three areas that I believe are relevant to the terms of reference of this inquiry.

1. **Proposed changes to the two-tiered Medicare rebate system**
   I hold endorsement in two specialized areas of practice with the Psychologists Board of Australia. I am endorsed as both a Clinical Psychologist and a Clinical Neuropsychologist. To gain access to these specialist titles I completed a BA followed by first class postgraduate honours in psychology. I then completed a coursework PhD in Clinical Psychology and Clinical Neuropsychology. I have been fully registered with the Queensland Psychology Board since 2001, and have worked as both a clinical psychologist and clinical neuropsychologist. I currently work part-time within Queensland Health, and part-time in private practice.

   Regarding the clinical psychology specialisation, it is important to recognize that specialist endorsement as a Clinical Psychologist is only possible with a minimum of eight years' training. It is the only profession, apart from Psychiatry, whose entire accredited and integrated postgraduate training is specifically in the field of lifespan and advanced evidence-based and scientifically-informed psychopathology, assessment, diagnosis, case formulation, psychotherapy, psychopharmacology, clinical evaluation and research across the full range of severity and complexity.

   In contrast, registration as a generalist psychologist is possible after a basic degree with honours in which no practical therapy skills are learned, followed by two years of supervised training. My concern is that the skills learned in these two years will be very dependent upon the skills and knowledge of the person supervising. Certainly the two years training cannot be equivalent to the comprehensive training received by those psychologists who undertake either masters or doctoral level studies with a host of highly qualified professionals providing the training. Certainly, based on reports from both public system and private practice clients, there are generalist psychologists working in private practice who are “very nice to talk to” but who can offer little in the way of the evidence based therapy necessary to help clients effect change. I recall many years ago recommending a close friend go to a psychologist to learn strategies to assist with his work stress. He went twice to a generalist psychologist. In the first session she gave him a questionnaire to fill out – end of session - $100 please. In the second session, she told him she had scored up the questionnaire and that he was stressed (no news to him). She advised him to get a new job – end of session - $100 please. This is, I hope, an extreme case, but it is nonetheless a true case.

   I believe that the superior training and skill set of the endorsed clinical psychologist must continue to be acknowledged. I am proud to call myself a clinical psychologist, and do not begrudge the years of poverty I underwent to achieve the knowledge and skills I now possess. I do believe, however, that the proposed abolition of the two-tiered system would effectively discourage others from following this path. By abolishing the two-tiered system currently in place, the government would effectively be sending the message that there is no difference between someone who has

undertaken years of rigorous studies and is recognized by their professional board as having specialized clinical skills and someone with two years "on the job" training.

2. **The impact of changes to the number of allied mental health treatment services for patients with mild or moderate mental illness under the Medicare Benefits Schedule**

   Those clients presenting with only mild presentations are unlikely to be affected by the cuts to session numbers. Those with mild presentations can often achieve positive and lasting results in around six sessions (sometimes less) when treated by a competent clinician.

   The treatment of clients who have moderate to severe mental illness, however, is a very different matter. These clients often tend to have quite complex presentations, and even when seen by an endorsed clinical psychologist who specializes in complex and chronic mental health problems, might require extensive and ongoing treatment. In some cases, even 18 sessions a year would likely not be sufficient to adequately support the psychological well-being of the client.

   I feel strongly that the reduction in the maximum number of sessions available to clients is likely to be detrimental to the mental health of those clients who most need psychological therapy.

   In addition, I believe that clients who have moderate to severe mental illness should be seen by specialist practitioners, i.e. clinical psychologists, who have the knowledge and skills required to deal with this complex and diverse client group.

3. **Lack of provision for Medicare rebates for specialized neuropsychological services**

   Neuropsychology is the specialization of brain-behavior relationships, which involves assessment of any or all of the following: cognitive abilities, intelligence (IQ), emotional functioning, personality and academic skills. The neuropsychologist's expertise is in the ability to evaluate individual brain functioning as it relates to these areas. If damage or inadequate brain development occurs, a change in abilities or atypical functioning may result, which the individual may experience as difficulty performing general or specific tasks, decline in functioning or emotional dysregulation. While the individual may externally appear healthy and capable, improper brain functioning often causes devastating effects that if not properly understood can further impair social, occupational, educational and psychological functioning.

   As an endorsed clinical neuropsychologist working in private practice I am concerned that there is no provision for medicare rebated services to cover the psychological needs of people with neuropsychological disorders. Neuropsychological disorders (e.g., cognitive/behavioural difficulties due to neurological, medical, developmental disorders) are not the same as mental health disorders (as defined by the mental health funding scheme), but neuropsychological disorders have significant mental health ramifications (e.g., adjustment issues, anxiety, depression, postictal psychosis, etc)

In addition, people with neuropsychological disorders often have disabilities that are life-long, and sometimes progressive, with major ramifications to their psychosocial adjustment, education, careers, and families. Their needs are not being met by the focus on only providing psychological assistance to people with mental health disorders.

There are not enough services in the community available to support people with neuropsychological disorders, especially those with noncompensable conditions, or aged under 65. In Queensland, for example, there are very few community services that deal specifically with clients with an acquired brain injury. There are very few supported or residential care options available, leaving a huge burden of care on families. Those organizations that do exist are often stretched in terms of resources.

Even a person diagnosed with a mild head injury may have significant cognitive and psychological difficulties as a result of their injury. Often, though, they do not get the opportunity to access neuropsychological services, including assessment and interventions, that may well provide the education and strategies needed to compensate for the difficulties they are experiencing. Neuropsychological assessment and intervention are intended to improve understanding of people's problems, and to help improve their adaptation to them, or to improve the care provided by others through education and individualized strategies.

It could be argued that the focus of providing psychological services to people with mental health conditions is a form of discrimination against people with neuropsychological conditions. These clients have a significant need for therapeutic psychological interventions that they often cannot afford to access without medicare rebates. The World Health Organization has said that neurological disorders and disease account for the largest proportion of medical disability in the developed world, yet Australians with these conditions have been neglected by the mental health funding initiatives of recent years. Currently the only people that can access subsidized private neuropsychological services are those with a DVA card. Otherwise, there are no medicare rebates for neuropsychological assessment and treatment services.