

Friday, 29 July 2011

Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600
Australia

The Committee Secretary,

Provided is my submission for the Senate Standing Committees on Community Affairs consideration regarding the Inquiry into Commonwealth Funding and Administration of Mental Health Services.

I am the Principal of a small clinical psychology service operating within the Sydney metropolitan area. I hold a Bachelor of Arts – Psychology degree, a Postgraduate Diploma of Psychology, and a Master of Clinical Psychology degree. In addition, I hold a Diploma of Clinical Hypnotherapy, and have trained in the use of *Eye Movement Desensitisation and Reprocessing* [EMDR]. I undertake the clinical assessment, psychiatric diagnosis, and clinical treatment of individuals presenting with mild to severe mental health disturbances. I am a Specialist Clinical Psychologist in full time private practice, with full registration with the Psychology Board of Australia, and endorsed in the area of Clinical Psychology. I hold current registration with Medicare Australia providing Clinical Psychology items, in addition to my registration with WorkCover NSW. This service operates as a full time private clinical practice, and has done so since 2006 in one form or another. From practice data, approximately 60% of the practice's workload is under Medicare's Bulk Billing scheme, and a further 26% receive a Medicare rebate following full-fee services – totalling approximately 86% of clients of this practice either do not pay consultation fees or are reimbursed through Medicare.

The majority of the clients being engaged by my service in clinical psychological therapy have multiple factors impacting on their general functioning and well-being. The majority of the clients undertaking therapy within the clinical services that are offered by my services include individuals with moderate to severe psychological disturbances. From practice data, this equates to 64.3% of individuals utilising these services with presenting issues including (but not limited to) severe depression, chronic pain, severe anxiety, suicidal tendencies, sexual dysfunctions, posttraumatic stress, abuse, substance abuse and eating disorders. More than 90% of these individuals have maintain therapeutic engagement for more than 12 months due to difficulties resolving their main presentations.

As you can appreciate, the psychiatric disorders these patients present with meet criteria under the *Diagnostic and Statistical Manual for Mental Health Disorders, 4th Edition*, Text Revision [DSM-IV-TR], impacting on

their general functioning in such a way that they are unable to engage in employment activities, unable to obtain and / or maintain relationships, and / or unable to engage in activities of daily living, for an adequate quality of life. Further clarity of the severity of their conditions can be evidenced by their often inability to attend therapy. Many of these individuals have not previously obtained assistance from clinicians, which only enhances their perceptions of hopelessness and helplessness. This perception only makes it harder for them to attend therapy, and then maintain therapeutic gains by adhering to treatment strategies and the regularity of therapy attendance.

Reductions in the number of consultations allowable under the Medicare system **will have a detrimental effect on the patients of my practice.** It will make access to therapy even more difficult due to there being a short term perspective on mental health disturbances, and thereby reinforcing their stereotyped perceptions of psychological services. In addition, they will be unsupported for longer periods of time with virtual no beneficial effect of therapy, when they actually do attend, resulting from the proposed restructuring of mental health services under the Better Outcomes initiative. This will essentially mean that clients who should be seen on a regular (ie weekly) basis, will now be seen on a monthly basis, and the consult will actually have a negative impact as clinical treatment strategies will likely be perceived as ineffective, due to the lack of frequent development and reinforcement. Further, utilisation of less experienced and less clinically competent practitioners, through alternative longer-term programs, will likely result in greater psychological damage being caused to these individuals as a result of the underestimation of the severity and impact of the presenting conditions.

The differential funding under the current system provides for clinical practitioners to be financially compensated and professionally recognised for training and experience undertaken in their chosen field of clinical psychology, and for this training, knowledge, and competence to be recognised on a daily basis with the various complex long-term presentations. Clinical Psychologists are trained in comprehensive clinical assessments, clinical diagnostic skills, case formulations, and treatment provision within an evidence-based framework. This level of training is equivalent to a psychiatrist, and the expertise in clinical delivery of psychotherapy and psychiatric diagnoses is at the same level of expertise of a psychiatrist. The two-tiered Medicare system provides for this recognition.

Further, motivation in undertaking specialised training in clinical psychology is a critical consideration. Although there are a number of accredited programs offered, entrance to these programs, whether Master's or Doctoral, are competitive and rigorous. The programs themselves are intense and difficult, and require personal and financial sacrifices to maintain a high level of training. For the clinical psychology trainee it is an expectation, following 8 years of sacrifice and hard work, to be adequately compensated and recognised in the field. The renegotiation of the boundaries between clinical training and the other specialities within the profession will likely result in demotivation to

uptake complex psychiatric presentations and / or the driving competition for academic places in clinical programs. In short, the Universities will lose out and **there will be a 'dumbing-down' of the profession!**

Personally, I undertake this work because I enjoy it. Although the remuneration is not congruent with the training and experience, such as Economists, Accountants, Psychiatrists, and even general medical practitioners, the satisfaction following positive therapeutic outcomes provides for overlooking of the inadequacies for the financial compensation. However, just like any other profession, there is no place for altruistic stereotyping when engaged in this work. The economic gains of the clinical speciality is a motivating factor, and **must not be overlooked**. Reconsideration for the motivation to continue engaging in clinical practice is a significant direct outcome of the impact of the current proposed changes brought before the Senate. Admittedly, previous to the introduction of allied health professionals on the Medicare Items Schedule, access to clinical practitioners was driven by economic realities. Since the introduction, the community's need for psychological services, particularly for clinical psychology services, has been realised. Clinically Psyched was established to assist meeting this need. However, as mentioned previously, **due to the significant sacrifices personally and financially in training and becoming a highly competent clinical practitioner and undertaking regular ongoing professional development in order to maintain high-level competence, it is unacceptable to lose this recognition, and it is unacceptable to lose the financial remuneration that accompany the work in which I am engaged.**

From this perspective, the changes proposed will deliver a message to the community that a clinical psychologist has no discernable skills from other non-clinically trained psychologists when it refers to mental health and psychiatric disturbances. This message will be that, I as a clinical psychologist, having trained for years, possess skills that are no different to a non-clinically-trained psychologist, social worker, occupational therapist, or mental health nurse. **This lack of recognition and the subsequent awarding of the same, equates to parliamentary members holding a portfolio as being referred to as 'only public servants' with no additional financial compensation other than that paid at the lower grades of their respective portfolio agencies. It is unlikely many politicians would compete for such positions if this were a reality within our political system.**

It is imperative that this government maintains the appropriate perception of psychologists with clinical training as a speciality and retains the relevant financial reward. It is imperative for the future of the profession and the psychological wellness of those individuals with moderate to severe psychiatric disturbances.

It is recommended that:

1. Clinically trained psychologists as a speciality with specific training in clinical assessment, diagnosis, and treatment of individuals with moderate to severe psychiatric disturbances are recognised;
2. Clinically-trained psychologists require adequate financial remuneration at a level reflecting the training, skills, and knowledge for high-level competence in the profession – that is, maintaining a two-tier remuneration system through Medicare;
3. The current number of consultation sessions made available to a clinical psychologist under the proposed changes are inadequate;
4. The number of consultations available for clinical psychologists be increased, and not reduced, to 30 allowable sessions per calendar year, due to the nature of the individuals accessing our services;
5. The removal of non-psychologist items from the Medicare Benefits Schedule and the Better Outcomes Initiative thereby providing an avenue of reduced Federal expenditure;
6. There be acknowledgement of the dangers of the ATAPS program and remove non-clinically trained professionals, thereby ensuring the program is retained for more longer termed recipients being trained by specialist clinical experts.

I must make note that should the abolition of the two-tiered system and the reduction of eligible sessions be implemented, it may result in my private practice no longer being viable, or those in need of mental health services through bulk billing will be charged full fees – thereby the entire process becomes redundant, and there would be little doubt of my certainty to remain committed to the profession beyond implementation.

I hope this submission provides you with sufficient information to assist in making a more appropriate recommendation for legislation, by improving on the current Medicare provisions.

Kind Regards