26 July 2011

I would like to make a submission to the Senate Enquiry into the Commonwealth Funding and Administration of Mental Health Services. In particular I would like to respond to the reduced number of sessions and possible cessation of the two tiered payment system for Clinical Psychologists.

Firstly, I am greatly concerned about the Government's rationale behind reducing the number of sessions available to the general public who are not severely socioeconomically disadvantaged enough to be eligible for the ATAPS program.

My concerns include the following:

The Government has appeared not to recognize the diversity of presentations for those with mental health issues that would warrant treatment. Herein, as a Clinical Psychologist, I am often referred patients by local General Practitioners to my Practice locations, whose clinical presentations are moderate to complex in nature. Herein, it is not unusual for referred patients to have comorbid Axis I Disorders, that is concurrent Depression, Post Traumatic Stress Disorder, Alcohol / Substance Dependence Disorder(s), and Generalised Anxiety and/or Panic Disorder with Agoraphobia, and at times may also have an Axis II disorder, that is a Personality Disorder according to full diagnostic criteria as assessed by the Diagnostic Statistics Manual – Version Four (DSM-IV). For example, I would have a local GP who would refer for someone with a range of difficulties which complicate the 'formulation' and treatment thereof. When summarizing the psychological literature reading the recommended treatment for a patient with comorbid Axis I disorders, without an Axis II disorder, 12-18 sessions are often only suffice to a minimum extent. Some clients have had psychological difficulties for a few to several years before presenting and would not be 'cured' in ten sessions only.

Further, the Fact Sheet released in May 2011 titled, "Cap Allied Mental Health Services", stated, 'almost three quarters of people who received an allied mental health service after a GP Mental Health Treatment Plan only needed between one and six services', and '87 per cent of current Better Access users receive between one and ten sessions, and will be unaffected by the new cap'. I would like to report that I average seeing between approximately thirty-five and forty patients per week in my Practice across three locations in the St George and Macarthur regions. In my patients' case the statistics would be reversed wherein only approximately 10% would not utilise the full twelve sessions available under the current Better Mental Health Access Program. Herein, they are motivated to gain psychological improvement as it has limited their social and often occupational functioning to a clinically significant degree – the hallmark of a 'disorder'. On occasion some people may keep a couple of sessions for a later stage in the year lest they 'relapse' and need some further support. Finally, if only 13% of those referred under this scheme need more than ten sessions then I don't understand how *cost effective* this would actually mean in real terms. The costs the Government would be saving in fewer 'crisis' services required and assisting these people maintain their general occupational and / or social functioning would I imagine outweigh those costs of the extra 13%.

Further, I have not read anything in previous correspondence to us as a profession as to the statistical basis for the Medicare claims of the above statistics. Were they taken over one month, one year, three years and was this the whole Medicare data base or just selective auditing to generate these statistics?

Were these statistics from Clinical Psychologists, Psychologists or Social Workers, and what proportionate representation?

Finally, if those who are making these rulings that will have significant impact on our society were as familiar with mental ill health in their work load as those in the profession they would most certainly re-evaluate this *reductionistic* measure.

Secondly, I would like to express my concern regarding the potential cessation of the two-tiered payment system for Clinical Psychologists as compared to those who are Psychologists without the extra training.

Since the mid 1990's it has been well known in University training that to become a Clinical Psychologist it would necessitate completion of six years of tertiary study, and one year of supervised full time practice or two years' part time supervised practice. Since the formation of the National Board of Psychology (AHPRA) the supervised practice component has now doubled post post-graduate training. Serious commitment to *specialize* in clinical psychological health presentations is needed to reach such high standards of professional attainment in this field.

To optimize the chance of gaining admittance to the Clinical Psychology Masters generally the top twenty (20) under graduate students for those with Psychology Majors in their undergraduate degree would be chosen per year in different universities to undertake an Honours Year, which would then stand the student in better stead to gain admittance to the Masters program. Of more recent years those with a top passing level in the Bachelor of Psychology program would gain admittance to the Honours Program. Often an interview process would then be part of a selection procedure to attain entrance into the Masters of Clinical Psychology Program. As well as the academic rigor and qualifications gained by the Masters of Clinical Psychology Program there is also a component of 1,000 hours supervised Clinical Placement Hours across a range of clinical psychological mental health fields, that is children and adolescent, hospital settings, adults and specialized fields. Such post graduate training is of great personal and occupational cost, as well as academic rigor, to those who commit themselves to that path.

At one stage I personally considered opting for two years supervised registration however found that at that stage there was no 'Board approved' supervision training in place and the Supervisor I liaised with could not assist me as to the detailed means for my meeting of the competency in my current role working in an Adult Homeless Refuge dealing in Case Management.

Whilst I do not wish to in any way discredit those who have not chosen to take the Clinical Psychologist route as set out above, nor minimize their role in the servicing of mental health difficulties, the Clinical Psychology training program as outlined above equips Clinical Psychologists to correctly assess, diagnose and treat cases of moderate to severe presentation as well as the complexity abovementioned. Until the formation of AHPRA (the National Board of Psychology) there was only 21 hours of psychology placement work per week over a two year period. Following a Masters of Clinical Psychology there also needs to be a supervised full time working position in Clinical Psychology for one year, or two years part time.

I have had 'four plus two' Intern Psychologists approach me for supervision who are working as Case Managers for Disability Unemployment Services, for example, who would not have anywhere near the in

depth training and supervised experience that was offered during my Clinical Psychology Masters and post Masters' supervised work experience in a clinical setting that the Masters afforded.

Herein, to have completed a Masters of Clinical Psychology is to say that one has gained 'mastery' at a level of competence to assess, diagnose and treat presentations of a more complex and severe nature. This has become a standardized measure of competence that must protect the more vulnerable of the those with mental health difficulties. This has been recognized by several referring General Practitioners who will refer to Clinical Psychologists when a client has a more severe presentation, rather than their own general Psychologists working in their own Medical Centres. Further, it is not unusual to have a patient in our practice who has gone to a generalist psychologist and they have not been diagnosed correctly. Like any other medical profession if the diagnosis is incorrect then the treatment will be misdirected and inappropriate, not gaining a good clinical outcome for the patient. Further, if the patient does not perceive a benefit from the treatment they will terminate treatment earlier than the recommended time frame.

The matter of the recognition of Clinical Psychology as a 'higher award' was successfully won in 2001 when heard by the Full Bench Hearing of the Industrial Relations Commission in Western Australia, wherein an industrial case reclassified the Clinical Psychology discipline as *higher* than its more general psychology training. Considering that we have the lowest standards in the western world in training in Clinical Psychology let us not reduce the standard by which we assess competence to treat those dealing with psychological and mental ill health. Otherwise, what measures do we have that those who are treating the more complex and severe mental health presentations have 'mastery' to do so?

It is of concern to me that the distinction in training and equipping in the area of Clinical Psychology is yet again being brought into question and I hope that this question is now being clarified and answered for the Senate Committee.