(...)

August 2nd, 2011

Dear Ministers

The following is written as a personal view and does not represent any organization or employer. (...)

The following points are raised for consideration during the process of reviewing funding and administration of mental health services in Australia. Psychology professional bodies have articulated many important points. I am adding some details.

The enquiry provides an opportunity to provide reasons for changing from *Endorsed area of practice* to *Specialist Title* for both Clinical Psychologists and Clinical Neuropsychologists.

1. Both the consumer community and referrers are confused. Who has expertise? Referrers to our services would appreciate greater clarity. A Pain Management Consultant recently told me that psychology descriptions are too confusing when working out where best to refer Public Hospital patients onto community based services. The tradition of using “Specialist” as a title improves clarity and transparency for both the consumer and referrer.

2. Patients have reported previous inappropriate and less skilled interventions that extended their suffering and possibly made their condition "chronic" (in both private practice and public health). Specialist Title can act as a *gatekeeper* limiting service delivery to vulnerable consumers, to those with established competencies, tertiary training, associated supervision and continuing professional development (CPD). This is consistent with Health regulator’s responsibility to protect consumers of Mental Health/ multi disciplinary Medical services. Monitoring by an informed professional body (e.g. APS) is another accountability procedure.

3. Workforce problems need to be placed in perspective. I understand the work-force issue. It was a privilege to work on a National Counselling Panel where various levels of *counsellors* were "accredited" nationally due to this problem. However, after 26 years as a practising psychologist, (initially as 4 year plus 2 year supervision in rural NSW, then as a tertiary trained Clinical Psychologist/ plus 2 years supervision /ongoing professional development), I can assure you that there are significant differences in competencies. A clear title of *Specialist* would facilitate appropriate gate-keeping/ triage for higher risk consumers, as currently practised in the medical profession.

Increased support for tertiary training places / staffing of programs/ may be a better solution to "work force shortages" in combination with Innovative treatment programs for rural/ remote populations, supported by APS, specifically funded institutes (Black Dog Institute) and Universities.

3. Retaining skilled Clinical/ Neuropsychology professionals in the public Health system is important. In public health physios established "productivity" through 15 minute effort logging (suited to physical exercises, concurrent patients, linear, concrete, medical treatment model). There are difficulties capturing work of psychiatry/ psychology in this model. Reflection for case formulation, treatment planning and review are essential ingredients (to name a few). We all understand that funding is linked to productivity, but *one hat does not fit all*.

4. Clinic models, GP as centre for community based services and Public Hospitals: Recent experience in a multi disciplinary Pain Service, at a major teaching hospital, demonstrated that all team members (Physiotherapists, Medical Consultants, Occupational Therapist) relied on the Clinical Psychologist to diagnose co-morbid mental health conditions, manage fear avoidance, motivate engagement with (physical/ psychological) treatment in order to get people back to normal living. Research in pain has established that psychological factors, such as *catastrophizing,* are central to recovery in persistent pain conditions. Can we establish sufficient incentives to maintain multi-disciplinary services in Public Teaching Hospitals.

I understand that Physiotherapists are applying for Specialist Title. Many work outside Private / Public Hospital systems. Some physiotherapists and Clinical Psychologists have established successful private practices with shared rooms. I have a commitment to public health – in my experience it wells very well for patients.

5. Training incentives for next generation Clinical Psychology / Neuropsychology to maintain a Mental Health workforce: Can Public Health at a state and national level make the same commitment to our profession, as overseas and in WA (now under threat), by awarding Specialist Title to maintain standards for consumers, incentive for the psychologist and specialist professional role in care related decisions? Specialist Title may provide an incentive to enter the profession in a changing Health system: i.e. to retain w*orkforce*. Trainees spend a significant amount of money and time to obtain tertiary qualifications in psychology with ongoing costs for accreditation. Clinical Psychologists/ Neuropsychologists have the training and skills to assist consumers to manage serious symptoms and reduce the burden of care on families, community and health services.

6. The incidence of complex and chronic conditions, such as, depression and dementia is rising. Under-trained and inadequately resourced services will burnout or worse, lower the National standards of care for complex physical / mental health conditions. Every person I have treated required "exercises" for both mind and body during the course of their recovery with input from “Specialists” working together. For example, approximately 10 years ago with seeding grant monies we implemented a *CBT with Exercise program* now run more broadly as *Exercise the Mood*. This is an example of how Clinical Psychologists apply research and clinical know-how to implementing innovative programs. Physical activity as part of a CBT program works well.

Thank you for considering the above points in working towards improved Mental Health programs.

Yours sincerely

Janet Benson
Senior Clinical Psychologist