

Submission to the Senate Community Affairs Committee into Commonwealth Funding and Administration of Mental Health Services

I have been a practising psychologist (and then clinical psychologist) in regional areas since 1980. My observations are based on my experience within a number of State Government Departments (including Health) and in private practice since 2006. It is also based on regular contact with a wide network of psychologists and close contact with the new generation of both psychologists and clinical psychologists, through providing individual supervision of both.

I wish to address the following terms of reference:

b. (iv) the impact of changes to the number of allied mental health treatment services for patients with mild or moderate illness under the Medicare Benefits Schedule

For many patients, the impact of reducing from 12 to 10 sessions will be minimal. However, those with moderate levels, which include one or more co-morbid disorders will not be able to effectively complete their treatment in 10 sessions.

In my practice, only a tiny number of patients have required up to 18 sessions. Cutting the number of sessions for that small proportion may result in negligible savings.

c. the impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program

There has been extensive data collected with the aim of describing this impact empirically. I would like to simply make the point that the program is clearly achieving its purpose – improving access to mental health services. I work in a regional area with a high proportion of the population being economically disadvantaged. Especially in the first few years of the program, many patients had previously received no treatment at all or had relied solely on medication, as they were unable to afford to access psychological services, even if they were aware of the potential benefits. Research indicates that a combination of medication and psychotherapy is the most effective treatment for many mild-moderate psychological disorders. But many people seeing a psychologist for the first time were previously unaware of that. As many had a low level of formal education, they tended to be limited to a medical view of their condition, the “chemical imbalance in my brain” view, with no awareness of the potential for improved self-management arising from psychological therapy. The long-term impact on the mental health of the community has yet to be seen, in terms of improved functioning and relapse prevention.

e. mental health workforce issues, including:

- (i) the two-tiered Medicare rebate system for psychologists,**
- (ii) workforce qualifications and training of psychologists,**

(i) The two-tier system aligns with professional standards in psychology, embodied in industrial awards (e.g. NSW Dept. of Health 2008 award) and in national registration requirements for speciality endorsements.

The failure of the profession to effectively communicate the difference in training and expertise between psychologists and clinical psychologists is regrettable. It is somewhat attributable to the brief of the APS to represent and promote awareness in the community of ALL of their psychologist members, including generalists and those working in numerous specialisations.

The fact that many consumers as well as GPs and GP clinic practice managers do not know the difference does not mean there isn't one. Many patients are still confused about the difference between a psychologist and a psychiatrist.

Some of the differences in outcome may be obscured by the non-specific effects of therapy. Research indicates that a large part of the effects of psychological treatments are the benefits of the emotional support of a close therapeutic alliance with a helping professional. However, that does NOT mean that the specific expertise of the clinical psychologist is irrelevant to outcomes.

An example is in the treatment of anxiety disorders. Although some generalist psychologists certainly offer appropriate treatment, anecdotal reports yield some surprising oversights. For example, a client's mother reported to me that her agoraphobic husband had received two blocks of 18 sessions annually, from two different psychologists, neither of whom had ever mentioned a graded desensitisation programme (the critical treatment). Of course, professional courtesy and Codes of Conduct precluded any comment to the client about the inadequacy of their treatment. A generalist psychologist reported to me that every one of their anxious child clients was receiving 12 sessions. In my experience effective treatment, well-grounded in decades of evidence, requires a maximum of 4-6 sessions, for even very anxious children. These are difficult issues to deal with when they arise. These issues also go directly towards the cost of the program.

I can offer a personal perspective on the difference. I worked as a generalist psychologist for 13 years, prior to undertaking the intensive, post-graduate specialist training to become a clinical psychologist. The four year degree consisted of a broad range of academic psychology subjects, such as Personality development, Learning, Perception, Cognitive Science, Life-span development – but only one subject in 3rd year on Psychopathology (basic introduction to mental illness). The Honours degree year was primarily research. Once I started working, I was extremely fortunate in receiving weekly training and supervision from experienced Senior Clinical Psychologists to induct me into the role of a professional psychologist.

I have to admit that, once I had been practising for a number of years, I resented the categorical statements by the Principal Psychologist of my employing organisation that the Clinical Psychology post-graduate courses were our “professional training” and should be mandatory. However, once I enrolled in the Master of Clinical Psychology and discovered what an extremely demanding and exacting degree it is, I had to revise my opinion.

I note that most generalist psychologists do not have the advantage of supervision by senior clinical psychologists and many have limited mental health experience. For years the requirement for registration in NSW was 2 years of employment (often an unpaid “placement”) for just 2-3 days/week in a psychology-related area, most often NOT in a mental health-related facility. Personally, I have even declined to supervise candidates who have requested supervision for registration, because I felt their placement was in a role other than the professional practice of psychology. The eventual competence can be highly

variable, depending on the qualification level of their supervising psychologist, whose only requirement is 3 years post-registration experience.

My contact with current psychology undergraduates indicates that the mental health-related training and exposure to mental health facilities is even less than it was 30 years ago. All of these concerns reflect the ongoing debate over decades within the profession about training models.

The formal degree in clinical psychology consists of an enormous scope and depth of coursework – all concentrated solely on the assessment and treatment of mental health disorders- and an enormous amount of practical training, through very close supervision of all cases seen. Most clinical psychologists find the course to be a profound experience!

Given the shrinking number of public sector employment opportunities, increasing numbers of clinical psychologists will rely for employment on Commonwealth funded schemes such as the Better Access program. The disincentives to undertake the rigorous, costly and demanding clinical training would be considerable if there was no differential in rebates. Many clinical psychologists no longer do Workcover work, precisely because of the reduced payments and lack of recognition of specialist qualifications.

Where I currently offer bulk-billing to at least 40% of my clients, I could not afford to do that if the rebate for clinical psychology services was reduced. This then becomes an access issue for the most disadvantaged clients.

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