Senate Community Affairs Reference Committee inquiry into Commonwealth Funding and Administration of Mental Health Services

To the Honourable Members of the Senate Committee Inquiry into **Commonwealth Funding and Administration of Mental Health Services, I respectfully submit the following information in responding to identified sections of the Committee's Terms of Reference:**

(b) Changes to the Better Access Initiative, including:

(ii) The rationalisation of allied health treatment sessions:

As a clinical psychologist who has provided a clinical psychology service in regional and rural South Australia since 1990, I have genuine concerns regarding the impact of reducing the number of session available for clients requiring psychological therapy.

It has been my experience, both when I worked in the Public Mental Health System, and in the past 13 years in private practice, that most clients referred, by General Practitioners, Paediatricians and Psychiatrists, are most definitely presenting with moderate and more frequently, severe mental health problems, often of a chronic nature.

Thus reducing the number of session available will deny the clinician the opportunity to provide the indicated treatment and consequently, clients, although experiencing in many instances, some symptom reduction, will be left unsupported after 6, possibly 10 sessions. A likely consequence of this change will be the return in severity of symptoms. This may in turn, impair a clients ability to trust in a system that appears to have abandoned them prior to treatment completion, thus the client may not recommence therapy in the new calendar year when a new referral could be made.

Importantly, from a Government and policy perspective, is the cost of not being able to provide adequate psychological treatment to enable clients to reach a level of mental health that permits adaptive functioning at social and occupational levels. The cost of clients experiencing a relapse, while personally very high for individuals, is also very high for society, in terms of admission or readmissions into hospital, and loss of productivity due to clients being unable to participate in educational, training or employment arenas. It is common for me practicing as a clinical psychologist in rural and regional northern South Australia, to receive referrals concerning clients who cannot be discharged from metropolitan psychiatric hospitals or country general hospitals until the can be discharged into my care.

This reflects the severity of the mental health difficulties clients I am treating experience. While there is discourse concerning mild to moderate mental health disorders, my clinical psychologist colleague and I frequently reflect on how wonderful it would be if that were actually the case, and how challenging it is for us to engage in time-limited therapeutic relationships with clients who have chronic and severe mental health problems, knowing there are no other avenues for clients to access mental health clinicians who possess the post graduate clinical training in mental health and are able to provide the indicated psychotherapy.

(iv) 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:

As described above, the impact in reduction of the number of psychological session available to clients will greatly impact on those clients presenting with chronic and severe mental

health disorders. The greater proportion of clients I see in the regional and rural areas I practice is by far, those presenting with moderate to severe mental health disorders. I have greatly valued being able to provide a clinical psychology service in the rural and regional areas where I live and practice. Prior to the advent of Medicare rebates for clinical psychology I was unable to provide a very much needed psychology service to clients unless they had compensable insurance support. Now I am able to bulk bill clients on health care cards who previously, had little or no opportunity whatsoever, of accessing a clinical psychologist. Apart from myself and a female clinical psychologist colleague, who also lives and practices in the same geographical area (northern rural South Australia), there have only ever been intermittent visiting Government or private psychologists. Neither the Community Mental Health Teams nor the Child and Adolescent Mental Health Service in this region have had a clinical psychologist (psychologists working in the Government Mental Health system in South Australia must have tertiary post graduate clinical training) for at least 15 years.

Since Medicare rebates were available for clients, my colleague and I have been able to see and bulk bill, clients with chronic and severe mental health disorders, often at the request of the Community Mental Teams, who tend to be staffed by new graduates, with no post graduate training in mental health, and who rarely stay in the rural locations for lengthy periods of time. The Community Mental Health team in the region I provide private clinical psychology services has informed me on a number of occasions that they do not provide psychotherapy but rather, seek to refer clients to practitioners or agencies that have those skills. Somewhat incredulously, I have been told by various staff from the local Mental Health team over a 5 year period, that the Mental Health team excludes clients who are referred to their service who have a history of sexual abuse in their childhood or adolescence as ostensibly, they have no staff with the training or experience required to provide a clinical service for such clients. Consequently, I receive referrals concerning clients who do not meet this curious referral criterion.

Again, while I am able and willing to provide a clinical psychology service to these clients, the challenge comes from having to deliver effective psychological treatment or interventions within 6-10 sessions. In view of the dearth of psychiatrists in my region, apart from very valuable visiting services that provide assessments but are not structured to provide ongoing therapy, there are no alternatives for proving other than brief interventions even for clients who present with chronic and severe mental health disorders.

(e) Mental health workforce issues, including:

(i) the two-tiered Medicare rebate system for psychologists:

As a clinical psychologist recognised by Medicare to provide Individual 'Psychological Therapy' I hold the greatest concerns for the future of this specialisation within my profession if the two-tiered Medicare rebate system should not continue. This will, I believe, have significant and aversive effects for the clients requiring and seeking expert, specialist clinical services in Australia. I also fear it will see the utter demise of university based clinical post graduate training programs across Australia, resulting in this country having the lowest standard of training for psychologists in the western world, and decimating research that contributes to the practice of evidenced-based treatments in clinical psychology.

The tertiary training of psychologists in Australia is claimed to be consistent with that provided in other western world countries, namely that of the scientist-practitioner model. This model described the initial 4 years of undergraduate training as the 'scientist' component of the model, with the 2 or 3 years postgraduate training provided in a clinical Masters or Doctorate degree, as providing the 'clinical' component of the psychologists training.

I would like to briefly reflect on my experience of having undertaken the 4 year program and subsequently, the clinical masters program, and how the 4 years training with 2 years supervision was for me, and inadequate and impoverished means of gaining the clinical

theories, experience and skills required to provide the services needed in the regions I practice.

Having initially worked as a 4 Year trained registered psychologist prior to undertaking an approved Masters Degree in clinical psychology, I am aware of the very significant difference the 2 years of full time equivalent University and Hospital/Clinic based training in clinical psychology meant for the breath and depth of my clinical skills and practice.

In fact, I actually undertook the clinical Masters Degree for that very reason. Being so isolated in the area in which I live and practice, it was salient to me that I needed to develop the assessment and clinical skills required to formulate a clinical impression of clients I work with and undertake further training within the context of a detailed, approved, accredited clinical course in which my clinical psychological skills would be assessed.

Although I had been awarded the 4th Psychology Prize by the University I attended, I was aware that even thought I had achieved academic success up to that stage of my training, I had not come close to being exposed to the clinical environments and undertaking the clinical course work and clinical placements inherent to all approved Post Graduate courses in Clinical Psychology. I consider such training and exposure to be critical to my current working as a psychologist. It is pertinent that such training experiences are, to my knowledge, only available in the context of an approved psychology post graduate clinical training program.

In South Australia, psychologist without a clinical Masters or Doctorate level of training are not eligible to apply for positions working in the Public Health system. Thus, 4 year trained psychologists are unable, even in an ad hoc fashion, to gain clinical experiences and skills in these clinical environments. Clearly, Government Health Authorities in South Australia recognised some decades ago that only those psychologists who had competed approved clinical post graduate training would have the depth and breadth of training required to even commence a career as a psychologist within their Departments. I was recently looking at the Medicins San Frontiers web site and saw that consistent with the state Government of South Australia, they would only accept psychologist volunteers who possessed post graduate Masters in clinical psychology. Clearly, this reflects the view that appropriate, accredited post graduate training in clinical psychology is mandatory for psychologists wishing to work in clinical arenas.

While I have met a worked with a number of competent four year trained psychologists, I have also been exposed to and concerned by the lack of training and experience in areas such as psychopathology, neuropsychology, child psychology, psychopharmacology, to name a few, displayed by a number of non-clinically trained psychologists who seem to consider working in rural and regional country areas requires less rather than more clinical training!

There is a very considerable commitment in terms of time, academic workload, clinical practicums and finances required to undertake a Post Graduate Masters or Doctorate Degree in Clinical Psychology. No doubt a number of experienced psychologists without formal tertiary training in clinical psychology have upskilled and developed themselves and their clinical practices. My great concern however, is that there is no formal means of determining this aspect of their training and formation. I have experience that very few non-clinically trained psychologists undertake the level of specified, rigorous and assessed level of training as would be provided by a formal tertiary post graduate clinical psychology courses.

On many occasions in various parts of Australia, I have discovered in conversations with other clinical psychologists that they shared experiences similar to mine. Namely, whether working for Government mental health agencies or in private practice, we seem to be asked to accept the most complex referrals/presentations, including those involving syndromal, developmental or neuropsychological aspects, as other mental heath practitioners were not able to undertake the indicated assessments or treatments.

It would be interesting to speculate what might occur in other health professions, for example in medicine, if:

1 non-specialist general practitioners, despite not undertaking a process of accreditation or assessment, were seen as possessing equivalent specialist training and skills as those practitioners who had completed a specialist training program to be admitted in to a specialist College,

or

2 a conclusion was made that the formal training and assessment required to be admitted into a specialist College, along with the ongoing approved and documented continuing professional training and development were of no consequence and that individuals with generalist, and importantly in the case of psychology, non-clinical training, were seen as having equivalent training and clinical skills.

(ii) workforce qualifications and training of psychologists:

Clinical post graduate training at the Masters or Doctoral level, as I understand it, is the minimum training required to practice as a psychologist throughout the Northern Hemisphere. If the two-tiered Medicare Rebate system for psychologist were to be removed, I would suspect there would be a devastating impact on the numbers of young students willing to embark on a minimum 6 year full-time University training, followed by a 2 year internship.

There would surely be less incentive to undertake the rigorous training required to become a clinical psychologist if one could simply undertake an undergraduate degree, with little if any clinical training, and move straight into practice. No only would there be no incentive in terms of salary or Medicare rebates recognising specialist training, the cost of undertaking a fully paid postgraduate course (in the tens of thousands) coupled with the extra 2-3 years of study which means no ability to earn an income, would make the notion of undertaking such important clinical training exceptionally unattractive.

Consequently, university Masters and Doctorates in Clinical Psychology would likely experience a dramatic reduction in students prepared to undertake such training without professional incentives. This would see the Psychology profession in Australia move towards a dumbing down of what is an evidence based, clinical mental health profession that has made and could continue to make, a very significant contribution to the clinical treatment and research areas of mental health services in Australia.

(iii) workforce shortages;

(f) The adequacy of mental health funding and services for disadvantaged groups, including:

(ii) Indigenous communities

While I have provided a service to Aboriginal clients in the region I live and work since 1990, for the past 6 years I have had the privilege of working one day a week with the Social and Emotional Well-Being team at the Aboriginal Health Service in . In that context, I provide a clinical psychology service to Aboriginal clients who are from a range of Aboriginal communities across the north and far north remote Sloth Australia.

I am in no doubt that the clinical Masters degree I undertook provided me with clinical and cross-cultural training that I did not receive in my undergraduate training. Workforce shortages are a persistent problem for most clinical disciplines in rural and regional areas. My experience of providing a psychology service in these areas for over 20 years has resulted in my unequivocal conclusion that a greater breadth and depth of clinical training and ongoing

professional development (as mandated by membership in the APSs College of Clinical Psychology) is necessary, rather than a lowering of standards. People living in rural and remoter regions of Australia typically have lower outcomes in physical and mental health epidemiological studies, and far less access to specialist services. This is not seen by other clinical disciplines as grounds to promote lesser clinical training, certainly not to advocate for a training standard that would see Australian practitioners having the lowest training standards and qualifications in the western world. Australians, from metropolitan to remote regions deserve better. In particular, funding for Aboriginal Health and Medical Centres in rural, regional and remote communities would ensure suitably qualified and culturally competent clinical psychologists would be able to provide services they would dearly like to be funded to deliver and that are desperately needed by communities with little or no specialist mental health practitioners.