Dr. XXXX XXXX, MAPS
Clinical Psychologist
NSW

26 July 2011

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

Dear Committee Members,

Re: Personal Submission - Senate Community Affairs Reference Committee inquiry into Commonwealth Funding and Administration of Mental Health Services -

The Senate Community Affairs Reference Committee inquiry into Commonwealth Funding and Administration of Mental Health Services is being guided by a number of Terms of References (TOR) in the context of cost savings in relation to the 2010-2011 Budget. This is a personal submission that seeks to address some of the TORs as well as provide a personal impact statement of potential changes to the current Better Access Programme.

One TOR seeks an examination of the two tired system for psychological interventions under the Governments Better Access programme. This TOR does not relate to, a work value issue for psychology, or provision of best practice services for suffers of mental health disorders rather it is a workforce issue with a significant political agenda. The Labour/Green government seems to be dismantling the Better Access programme introduced by the Howard Government and in its place creating a potentially more centralised and unionised workforce in the ATAPS/Medicare Locals model. It seems this gives the government portfolios more taxpayer funds for the big spending items such as The National Broadband Network and questionable mental health programmes that may

be unlikely to provide the access benefits of the current Better Access programmes. That is, a more centralised system that places additional transport requirements on clients in remote and regional areas to attend specialist mental health care professionals. The 'Worse Access' model being pursued by the Government reduces the access by those with a mental health problem as it centralizes the services and burdens those disadvantaged with additional responsibilities. This additional transport requirement is also in the context of our community being on a path of carbon emission reductions which in part seeks to reduce our individual emissions particularly around the use of motor vehicles and other carbon-producing transportation options.

In terms of work value, Clinical Psychology is one of nine equal specialisations within Psychology. These areas of specialisation are internationally recognised, enshrined within Australian legislation, and are the basis for all industrial awards. They have been recognised since Western Australia commenced its Specialist Title Registration in 1965, and it is the West Australian model which formed the basis for the 2010 National Registration and Accreditation Scheme recognition of specialised Areas of Endorsement. All specialisations require a minimum of eight years training including a further ACPAC accredited postgraduate training in the specialisation leading to an advanced body of psychological competency in that field. No specialisation should be referred to in a manner that creates the appearance of the same level of skill and knowledge as the basic APAC accredited four year training of a generalist psychologist. As is the case with Clinical Psychology currently, each area of specialisation deserves a specialist rebate with its own item number relating to that which is the specialist domain of that area of psychology (e.g. for clinical neuropsychology - neuroanatomy, neuropsychological disorders/assessment/rehabilitation, etc; for health - clinical health psychology, and health promotion; forensic - forensic mental health, etc). Specialist items for the other specialisations of psychology may mean that Clinical Psychologists might not qualify for any those second tier items pertaining to other specialisations. However, I respect specialisations within psychology and believe that if others undertake further training in specialisation fields and attain APAC accreditation for the specialisation then they should be entitled to receive remuneration to in part recognize

their skills as well as compensating for the cost of training and loss of potential income during training.

Regarding my specialisation, I wish to re-state that Clinical Psychology requires a minimum of eight years' training and is the only profession, apart from Psychiatry, whose entire accredited and integrated postgraduate training is specifically in the field of lifespan and advanced evidence-based and scientifically-informed psychopathology, assessment, diagnosis, case formulation, psychotherapy, psychopharmacology, clinical evaluation and research across the full range of severity and complexity. We are well represented in high proportion amongst the innovators of evidence-based therapies, NH&MRC Panels, other mental health research bodies and within mental health clinical leadership positions.

From my own experiences working within the Better Access programme for the past few years it has become clear that GPs, Psychiatrists, and Paediatricians refer to a Clinical Psychologist because like them they have undergone specialist training which has included mental health. The referrals reflect the complexity of the patient’s presentation, and the more complex are invariably referred to a Clinical Psychologist. The ‘worried well’ are typically referred to a Generalist Psychologist. Clinical Psychologists in many cases will refer non-complex cases to Generalist Psychologists who may be better placed to assess and treat the client.

For me personally, I came into psychology after a successful 20-years military career achieving specialist command roles. I subsequently incurred a $50,000 HECS training and education debt for a Clinical Psychology doctorate at the University of XXXXXX, and suffered a loss of income over the eight years. I will not remain in a Clinical Psychologist work setting that does not provide the work value recognition, delivery of best practice in care, and appropriate remuneration. I have seen this coming as a potential risk and sought individual contracts with Federal Departments (e.g. Defence) that require only those psychologists with specialisation training, i.e. clinical and organisational typically. I am also contemplating reducing my psychology work involvement.

I have concerns about two further issues that were not suitability addressed in the Government's recent study of the Better Access programme. These issues are in relation to relapse rate differences and inadequate treatments. Both have a potential adverse impact on the psychological wellbeing of clients and would likely result in an additional unnecessary cost. To overcome this problem it would seem that a best practice model is needed in the first instance, such that mental health patients are treated by mental health specialists.

It seems there are many significant research methodological issues that diminish the credibility of the study of the Better Access programme. The study did not meet fundamental standards of research design (it did not identify the nature, diagnosis, or complexity of the clients seen by psychologists by 'type of psychologist'; it did not identify the nature or type of psychological intervention actually provided; it did not factor in or out medication use by the client; it did not factor in or out therapy adherence indicators; it did not have a valid criterion measure actually related to a range of diagnoses or complexity in order to assess pre and post intervention condition of clients; it did not undertake follow-up assessment of clients, which is often the point at which the relative strength of any competent treatment becomes manifest; it did not determine relapse rates by type of psychologist; it was a self-selected sample of psychologists who self-selected their clients and clinically administered the research questions in session; it was not subjected to peer review); and what is needed is a well-designed prospective study aimed clearly at answering specific questions in accordance with principles of psychological research.

There is an anecdotal report that DoHA has had to follow a government imperative to demonstrate cost savings and that this is non-negotiable. However, it is abundantly clear that the obvious significant gap in mental health service provision is for those in the community presenting within the range of the moderate to most complex and severe presentations. Those people presenting with only mild presentations are unlikely to be affected by the cuts to session numbers from 18 per annum to 10. The treatment of the moderate to severe range is the unique specialised training of the Clinical Psychologist and, to undertake a comprehensive treatment of these individuals, more than thirty

sessions per annum are sometimes required. In this way, Clinical Psychologists should be treated as similar to Psychiatrists under Medicare as both independently diagnose and treat these client cohorts within the core business of their professional practices. However, this is unlikely to be granted presently given the government imperative to cut costs so it seems that the decision to cut session numbers for the specialist Clinical Psychologist Medicare items should be reversed immediately.

Yours Sincerely,

Dr. XXXX XXXX, MAPS
Clinical Psychologist