1 August 2011

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

I wish to address two of the terms of reference related to the “Better Access” initiative being considered in the current enquiry: the two tier system acknowledging the specialised skills of Clinical Psychologists and the cuts to rebated session numbers under the “Better Access” initiative

1. The two tier system acknowledging the specialised skills of Clinical Psychologists.

I support the 2 tier system that acknowledges the specialisation of Clinical Psychologists in the assessment & treatment of mental health disorders.

Clinical Psychology is one of nine specialisations within Psychology in Australia and is internationally recognised, enshrined within Australian legislation, and is the basis for all industrial awards. The clinical psychology specialisation has 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.

Clinical psychology requires a minimum of eight years training including a further ACPAC accredited postgraduate training leading to an advanced body of psychological competency in clinical psychology. Clinical psychology 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. Clinical psychologists 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. Clinical specialisation in psychology is either required or highly preferred for positions within government & private hospitals & community organisations. Senior level health professionals obviously recognise the benefits of employing clinical psychologists over generalist psychologists in the provision of services for their mental health clients.

Clinical specialisation should not 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. Clinical Psychology deserves its specialist rebate with its own item number relating to that which is the specialist domain of that area of psychology.

Comparing the training & expertise of clinical psychologists with generalist psychologists is akin to comparison of GPs who have generalist training with medical specialists who have an advanced level of training in their field. The public assessing psychological services deserve to be informed of the differences in training & expertise between generalist & clinical psychologists & specialist services should attract a specialist rebate. This is standard practice in medicine & other health service providers e.g. physiotherapists and should also apply to psychology.

2. The cuts to rebated session numbers under the "Better Access"

I object to the proposal to cap the maximum number of sessions available to people who access a psychologist under the Better Access to Mental Health Care at a maximum of 10 sessions. As a psychologist, my opinion is that these proposals will compromise the quality of care provided in a system that has been shown to be both efficacious and cost-effective. The 10 session limit being imposed on psychological consultations in *Better Access* must be reconsidered before it is put in place.

Like many of my colleagues, I share the view that positive steps are being made in recognising gaps in the mental health system. However, new investment in mental health care should not come at the cost of our existing services that are working well to improve the psychological well being of Australian citizens. The plan to cap psychological treatment at 10 sessions, falls below standard treatment protocol for the management of even the most uncomplicated psychological conditions. Recent research by the Australian Psychological Society (funded by the Department of Health and Ageing) shows that the average length of individual treatment for mental health disorders is 15-20 sessions. New research conducted by Harnett, O'Donovan and Lambert (2010) shows that for 85% of people to show clinically significant change in their level of symptom severity, around 20 sessions of treatment are required. This research shows that with 10 sessions of treatment, around half of people will need more psychological care to improve. These figures match survey data from the Australian Psychological Society about the work of psychologists in the *Better Access* scheme. Limiting the maximum length of treatment at 10 sessions is plainly unrealistic and will set many people up for failure in the system.

Along with many of my colleagues, I do not think it is fair to take such a tough stance on people who are already struggling with psychological distress. These new proposals apply pressure to both clients and the psychologists they consult with, to achieve results over a very brief period of contact. My concern is that this new policy will be frustrating for many people, who will simply give up. Furthermore, these cuts are likely to increase costs as those suffering mental health problems will be forced to consult a psychiatrist, attracting a higher government rebate, or be prescribed medication by a GP leading to higher pharmaceutical costs.

It is abundantly clear that there is an obvious significant gap in mental health service provision for those in the community presenting within the range of the moderate to most complex and severe presentations. Those presenting with only mild presentations are unlikely to be affected by the cuts to session numbers. 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 Psychiatrists are under Medicare as both independently diagnose and treat these client cohorts within the core business of their professional practices. We believe that the decision to cut session numbers for the specialist clinical psychologist Medicare items should be reversed immediately.
I urge you to reconsider these new proposals about the *Better Access* initiative and leave the length of treatment intact at 12-18 sessions.

Sincerely,

Dr Rachel Costa
Clinical Psychologist