Attention:
Committee Secretary

26th July 2011

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

As a Clinical Psychologist I am writing to express my deep concerns about the proposed changes to the Mental Health Services that relate to changes in the Better Access Initiative and the mental health workforce issues.

Terms of Reference
The two terms of reference that are of particular concern are:

- (b) (iv) the impact of changes of allied mental health treatment services for patients with mild or moderate mental illness under the Mental Benefits Schedule
- (e) (i) the two-tiered Medicare rebate system for psychologists

Assumptions
It would appear that proposed changes are based on the following assumptions, namely that:

- all patients presenting to psychologists can be classified as having *mild or moderate* mental illness
- the extra training and level of on-going Professional Development to maintain the classification of a Clinical Psychologist, as opposed to a General Psychologist, has no bearing on assessment and outcome of treatment.
- Clinical Psychologists do not have adequate expertise to treat *severe* cases
- The Better Access Evaluation was a piece of sound research, the results of which directly apply to these two terms of reference.

Challenges to the assumptions
1. The range of patients presenting for treatment is wide-ranging, including those experiencing single simple phobias to patients with complex anxiety disorders (such as post-traumatic stress disorder) and mood disorders (such as bipolar disorder), the etiology of which can be multi-faceted and deep-seated and can include such things as past trauma, dysfunctional family of origin, personality disorders and psychiatric disorder. Clinical Psychologists have the ability to complete a thorough assessment of the full gamut of possible mental disorders, and to make a differential diagnosis. From the experience of this team of psychologists that includes both Clinical and general Psychologists, general Practitioners are aware of the differences and refer the more complex cases to the Clinical Psychologists. It is also worth noting that in their referring

letter to Clinical Psychologists, the GPs often request an opinion on the assessment, diagnosis and management of their patients.

2. The extra training associated with Clinical Psychology involves the teaching of sophisticated psychological concepts. Without such training therapists do not have the ability to assess the contribution of complex factors involved in the emergence of mental illness problems. This is essential for a differential diagnosis of mental illness and the formulation of a treatment plan. Clinical Psychologists have the ability to select from a range of approaches and to systematically evaluate the effectiveness of treatment so that it can be adapted throughout to ensure that therapy is individually tailored to the needs of the patient.

3. Lack of recognition of expertise of specialist, rather than generalist, skills does not occur in other disciplines, particularly within the medical field. While General Practitioners can prescribe anti-depressants it is not assumed that they provide the same level of treatment and expertise as Psychiatrists. It should also be noted that the difference in expertise is also remunerated accordingly.

4. Best practice worldwide discriminates between Clinical and General Psychologists. To get rid of the two tiered system would be to place Australia out of step internationally, including Britain and the United States of America. It should also be noted that even within Australia this issue has previously been heard by the Full Bench Hearing of the Industrial Relations Commission in Western Australia in 2001.. Remuneration was pegged according to differences in definitions of different levels of expertise of Clinical and General Psychologists. Level 1 included supportive counseling and simple techniques, Level 2 circumscribed psychological activities as described by protocols, and Level 3 was associated with deep-rooted underlying influences that required a discretionary capacity to draw on a multiple theoretical base in order to develop individually tailored programs. General Psychologists were seen as appropriate therapists to undertake the first two levels but it was decided that only Clinical Psychologists should undertake the therapy required for Level 3 and that they should be remunerated accordingly.

5. A reduction in the current number of sessions available through the scheme may be appropriate for simple cases, however, this idea again fails to recognize the needs of patients with complex problems, and these patients are currently seen within the scheme. In fact severe cases would benefit from an increase in the 6 + 6 sessions with an extra six for extraordinary cases, rather than a reduction of sessions.

The proposal that patients with more severe mental illness should be assessed by a Psychiatrist after 6 + 4 sessions will cause a disruption to, and often a duplication of treatment approaches. The waiting time to see a Psychiatrist can be considerable leaving the patient without psychological input causing their condition to worsen. The impact for the client who has started therapy with one therapist and then has to change therapists has not been considered. For someone with a history of trauma who first has to build trust with the therapist and then has to re-iterate their story all over again it is obviously likely to be considerable but it is likely to be so for others as well.

Furthermore, it fails to recognize the diagnostic and therapeutic skills of Clinical Psychologists. Like Psychiatry, for Clinical Psychologist courses to be accredited they must included training specifically in the field of lifespan and advanced evidence-based

psychopathology, assessment, diagnosis, case formulation, psychotherapy, evaluation and research across the full range of severity and complexity.

6. The gap between Medicare funding and the cost of seeing a Clinical Psychologist will widen. This has the potential for more serious cases to be either referred to those without adequate training in assessment, diagnosis and treatment formulation, or the individual must find that money which can create financial hardship.

7. The conclusion that the outcomes for Clinical and General Psychologist are the same has been based on a piece of methodologically flawed research. The nature, diagnosis or complexity of clients, nor the type of intervention offered were not identified and so it was not possible to conclude that both groups of therapists was the same and yet this appears to have been the conclusion drawn.

In addition, the sample was based of self-selected psychologists who then selected patients to be included as subjects and the research questions were administered in the session all of which is likely to bias the results in favour of positive outcomes. A well-designed prospective study aimed at answering specific questions in accordance with the principles of sound psychological research is needed before conclusions are drawn.

Taken together, these points raise a strong argument against a single-tiered Medicare rebate system for psychologists. It clearly makes much greater sense to retain the current two-tiered system that recognizes the greater degree of expertise of clinical psychologists to provide mental health treatment to those experiencing mental disorders.

Yours sincerely,

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(Clinical Psychologist)