

4 August 2011

Attention: The Committee Secretary, Senate Standing Committees on Community Affairs

Re: Commonwealth Funding and Administration of Mental Health Services Inquiry

Dear Committee Members,

I write to you to put forward my opinion regarding several points you are considering as part of your Commonwealth Funding and Administration of Mental Health Services inquiry. Specifically I refer to the below points, in order of priority:

(e.ii) Mental Health workforce issues, workforce qualifications and training of psychologists.

(b.iv) Changes to Better Access Initiative, impact of changes to number of treatment services available to patients.

(b.iii) Changes to Better Access Initiative, preparation of care plan by GPs.

(e.ii) Mental Health workforce issues, workforce qualifications and training of psychologists.

Valuing Specialisations within Psychology

I strongly encourage the Senate Committee to recognise specialisations within the discipline of psychology, including all specialisations, and in the current context specifically valuing the specialisation of 'Clinical Psychologist'.

Recognition of specialisations is as imperative in Psychology as it is in other professions. For example, all General Medical Practitioners are doctors however specialist titles enable people to choose a medical professional who has skills in their specific area of need. Similarly, consideration of specialisations must be taken into account when engaging legal services. When purchasing property I would engage a conveyancer. Conversely if I was accused of criminal activity I would engage a criminal lawyer. Both are lawyers, both have trained for similar amounts or time, however they specialise in different areas and would not purport to be experts in the others area of specialisation. Thus, I pose the question, if you were struggling to deal with Schizophrenia would you like to know if the psychologist you intend to engage with has specific training in your area of need, i.e. Clinical Psychology.

Clinical Psychologists are specifically trained to be experts in assessing, diagnosing and treating the entire spectrum of mental illness. In fact, Clinical Psychology training along with Psychiatry are the only post-graduate training programs specifically designed to produce experts in the assessment, diagnoses and treatment of mental illness. It seems that until recently the specialisation of Clinical Psychology has been valued in Australia (Work Value Case in Western Australia), and also internationally (<http://www.apa.org/ed/graduate/specialize/clinical.aspx> or <http://www.clinicalpsychology.org.uk/>). Now in Australia within the context of Medicare, there seems to be a desire to abolish specialisations within psychology, specifically Clinical Psychology, and it seems that the underlying motivation is money. This is, in my humble opinion, very disappointing. Long before Medicare for psychology was introduced, I started on my path to becoming a Clinical Psychologist, which was a thoroughly considered and definite decision made as a mature aged student. I chose this path because after researching and assessing all the available options I easily concluded that Clinical Psychological training (including significant practicum, coursework and research) would provide me with the absolute best training available to enable me to help people to deal

with significant mental illnesses. Conversely, if I wanted to be a Counselling Psychologist I would have chosen that path, where mental illness is not necessarily the reason behind someone seeking help. Or if I wanted to work in business I would have chosen the path of Organisational Psychology, thus recognising that all specialisations are important.

Recognising Clinical Psychology is important because Clinical Psychologists not only work with people who are suffering from high prevalence mental illnesses such as Depression and Anxiety, but also work with people with low prevalence disorders. Clinical Psychologists are also often the people many other professional health care workers, including other psychologists, call or turn to when a difficult differential diagnosis needs to be made and/or complex treatment provided. Clinical Psychologists are specifically trained to provide differential diagnosis in complex cases. For example, a Clinical Psychologist has training and experience in differentiating between Autism, Aspergers Disorder and Attention Deficit Disorder, and then providing the appropriate treatment. Another example of where Clinical Psychological differentiation and formulation skills come into their own is highlighted in the following example: when a child presents with what seems to be primarily anxiety. Clinical Psychologists are experts in discovering that what seems to be the problem is not always the primary problem. A Clinical Psychologist has specialist skills that enable them to ascertain that the child actually has an unrecognised and untreated learning disorder and the anxiety is secondary to the primary diagnosis of learning disorder. Without specialist skills in differential diagnosis the anxiety would become the focus of treatment, however the underlying cause would never be addressed. The treatment is therefore neither efficient nor effective.

Clinical Psychology training explicitly teaches specialist skills in assessment, incorporating the use of standardised assessment techniques, to enable differential diagnosis of underlying problems that can often be masked by presenting problems. When taking this into account we can see that 'knowing what you don't know' is as important as what you do know. Similarly, it appears that within the debate about abolishing the recognition of Clinical Psychology as a specific specialty there is a general lack of knowledge and understanding about the unique set of skills that Clinical Psychologists bring to the practice of psychology. Just as a Sports Psychologist would bring a unique set of skills to their work, so do Clinical Psychologists. There is some evidence to suggest however that the unique contribution made by Clinical Psychologists is appreciated by some. For example, it appears that public Mental Health Services primarily employ Clinical Psychologists, specifically because they have the knowledge and skills to assist with the treatment of mental illness within the context of services that specialise in Mental Health.

It appears that one of the enduring arguments put forward by those adamant to abolish the recognition of Clinical Psychology as a specialisation is that all psychologists possess the knowledge and skills of a Clinical Psychologist. Again, I suggest it's difficult to know what you don't know. This point is explicitly highlighted by at least four of the submissions put forward to this Senate Committee. The submissions are from four separate psychologists who initially undertook the standard training path to become a psychologist. After working as 'generally trained/registered' psychologists they all undertook further training in Clinical Psychology. All four testify that without a doubt this additional Clinical Psychology training improved their ability to work with people with significant mental illness. In fact one psychologist points out that they considered themselves competent before they completed this extra training in Clinical Psychology, however, not in hindsight. These accounts demonstrate that it is hard to know what you don't know, and it seems that this is a critical point in the debate. I urge you to strongly weight the experiences of psychologists who have provided services pre and post additional Clinical Psychological training. In addition to these accounts, I personally know a psychologist who initially successfully became and worked as a 'generally trained/registered' psychologist (i.e. via the 4 years of undergraduate training plus 2 years of supervised practice path). She also subsequently enrolled in a course of Clinical Psychology and now frequently expresses her bemusement about the significant difference in skills and knowledge achieved via the different pathways for the specific purpose of assessing, diagnosing and treating people struggling with mental illness. Again in hindsight, she questions the competency of those who attempt to diagnose and treat the broad spectrum of mental illness without specific Clinical Psychological training. This is despite her good fortune of working for a government agency that provided supervision, professional development opportunities and training during her tenure as a generally trained/registered psychologist. She strongly believes that only specific Clinical Psychological training can equip psychologists with the skills and

knowledge they need to enable accurate diagnoses and treatment of the broad spectrum of mental illness. She has walked both paths, and I trust her insights.

In addition to bringing unique skills to assessment, diagnosis and treatment in the therapeutic sense, Clinical Psychologists also contribute extensively to other areas of the health care system more broadly. Many Clinical Psychologists are leaders in researching the efficacy of treatments as well as developing new approaches to treatments. Clinical psychologists are also involved in many NH&MRC Panels and funded projects. In fact, clinical psychologists make a substantial contribution to many clinical research endeavours.

To reiterate, it is with the specific intention of helping people with mental illness that Clinical Psychologists choose to train within the Clinical Psychology paradigm. As a psychologist training within the Clinical branch of psychology I would not for example practice as an Organisational Psychologist once I am registered as this would be beyond my level of expertise, despite having completed the same number of years of training.

Overall, my argument is that we can't all be experts in everything; however we can be experts in specific areas. This is why I urge the Senate Committee to not only to recognise but value all specialisations within psychology, and in this case Clinical Psychology.

(b.iv) Changes to Better Access Initiative, impact of changes to number of treatment services available to patients.

The high uptake of psychological services through the Medicare Better Access scheme demonstrates the community's need for psychological services. Unfortunately, this need was grossly underestimated in budgetary terms seeing a cost blow out. This underestimation has now resulted in the number of treatment services available to patients being decreased. Frankly, this seems counter intuitive. Firstly, because we know that untreated and even undertreated mental illness/health issues cost the community much more than just money. Secondly, we know that early intervention and treatment can have a significant impact on illness remission and can also act to curtail the progression of an episode before it incapacitates a person (which costs all concerned a lot of money). By decreasing the number of sessions available to patients the government risks people's treatment being incomplete and increases the chance that they will present again for future treatment, costing the government more in the long-run. Cutting the number of treatment sessions now may provide the government with some short-term monetary/budgetary gain, however I would argue that it will cause long-term monetary/budgetary pain because people are more likely to present again for treatment because they have had insufficient opportunity to address their issues initially. In considering this point, I urge the committee members to consider how difficult it is for them to change. Have you ever tried to change one of your behaviours, thought patterns, or emotional experiences? Let's think of a simple one: Maybe eat less and exercise more? It usually turns out to be harder than you expect. That's because change is difficult. Psychology is about helping people change; sometimes psychologists help people change their thoughts, feelings and behaviours, and sometimes they help people change the relationship they have with their thoughts, feelings and behaviours so that they do not cause them amplified distress. If changing your eating and exercise patterns are difficult, imagine how hard it is to change distressing thoughts, feelings and behaviours. It doesn't just happen. It takes time and hard work. If the number of sessions provided to facilitate change is reduced I believe it is less likely that change will occur. For the cost of a few extra sessions the first time a person seeks treatment, the government could save themselves more money in the long run. I propose the number of session's remains as originally set up: 12 sessions with 6 extra sessions in exceptional circumstances.

I provide you with this brief example of a case that required all 18 sessions, and I argue that the government would have spent more in the long-term if these 18 sessions were not available to my client. Within the last year I provided clinical psychological treatment to a gentleman in this late 20s. He was referred to me via the local mental health service after an acute suicidal episode that required an inpatient admission, in the context of ongoing depression and psychosis. This particular admission followed the suicide of his mother. This is clearly a complex and emotional case. Initially I saw this client once a week, which I and he considered necessary due to his significant suicidal ideation. Naturally, he was very scared of his suicidal thoughts. Due to the weekly sessions our therapist/client engagement strengthened and over time he was able to divulge more and develop a willingness to experience his distressing emotions instead of avoiding them, which was exacerbating his symptoms. We used all 18 sessions available to him under the Medicare system, and it was highly worthwhile. In the end he had returned to part time work and TAFE. I argue that the 18 sessions might look like they cost a lot up front, however in the long-term it costs the government less, and in this case they even contributed to an individual resuming their contribution to society and the economy.

Another point to add to the discussion of reducing the number of sessions, is that psychologists endeavour to conclude psychological treatment when clinically indicated and are not in the habit of continuing treatment just because a client has Medicare funded sessions still available. Psychologists are not interested in seeing clients who do not need psychological treatment. Firstly, because it is intrinsically unsatisfying for both parties. Secondly, because it is unethical to continue to see a client that does not need psychological treatment. Thirdly, because most psychologists have a waiting list they are not going to prioritise treating someone who does not need treatment. So, I beg the question, does the government not trust psychologists, professional health care providers, to bring therapy to a close even if a client still has available Medicare sessions? The reduction in available sessions suggests that they do not trust psychologists to use available sessions appropriately. The proposed change only acts to stifle clinical judgment around the number of sessions each individual client may need. Interestingly, psychiatrists do not have a limit on the number of sessions they provide and they often use therapeutic techniques that see clients in therapy for years. I think psychologists have shown they can make a significant difference in people lives in an efficient manner with the 12(18) session model and it should be continued to be supported.

It also appears that some high profile experts are purporting that the 12 (18) sessions model be reduced because some sections of the community are still under-supported by psychological services and they would like the funding redirected to those sections of the community. I am saddened that these experts would essentially like to 'rob Peter to pay Paul'. Of course youth and rural mental health services need more funding, but not at the expense of others in the community who have also demonstrated their need for psychological services.

In addition to the above, the committee may also be unaware that many proven courses of psychological therapy interventions are based on a 12 session plan. There is a broad understanding within psychology, which probably informed the original Better Access 12 sessions plan, that 12 sessions often provides time for effective and efficient change. Also, many empirically validated interventions are based on a 12 session plan, such as treatment for the anxiety disorder of phobia. I urge the committee to consider this in their decision making.

In sum, I urge the committee not to reduce the number of sessions available to clients; it's a recipe for short-term gain, long-term pain.

(b.iii) Changes to Better Access Initiative, preparation of care plan by GPs.

In my opinion preparation of Mental Health Care Plan's by GPs has added little value to patients psychological assessment, diagnosis or treatment outcomes through Better Access, apart from merely enabling the patient access to the system. In fact, the only outcome I have seen is that it costs the government a fortune. The Mental Health Care Plans I have received have often been poorly executed, often containing incorrect information and assumptions and have even contained incorrect diagnosis. It is odd that a GP would refer a patient to an expert for assessment but already provide the diagnosis. This doesn't happen for physical illnesses, GPs always wait for results of assessments to come back before they talk about diagnosis and it is usually the specialist who decides the diagnosis not the GP. So why are psychological referrals different? Also, why do GPs get paid to make a referral to a psychologist? They don't get paid to make other referrals. Furthermore and importantly, the content of Mental Health Care Plans are automatically subsumed within standard psychological assessment and case planning procedures, so GPs preparing this for a fee is adding no value to patient outcomes. In fact, I actually think it could be reducing patient outcomes in some cases. For example where GPs, who I am sure have the best intentions, make an incorrect mental illness diagnosis, patients get confused and it can impact treatment. GPs are not experts in psychological assessment, diagnosis or treatment, whereas Clinical Psychologists are. GPs need to know when to refer to a psychologist, just as they would to any other specialist health care professional, without encroaching on the work of that expert; and especially not getting paid for the referral. The money could be used for actual psychological services not just a referral.

I urge the committee to consider the lack of value the preparation of Mental Health Care Plans by GPs adds to a patients psychological assessment, diagnosis, and treatment, and I suggest that GPs make unfunded referrals to psychologists, just as they would to any other specialist practitioner.

In summary, I urge the Senate Committee to:

- **not only recognise but value all specialisations within psychology, and in this context Clinical Psychology;**
- **support the original 12(18) model for the number of psychological services available to clients;**
- **abolish GP funding for referrals to psychologists and redirect the money to actual services.**

I would like to thank the committee for their time and effort in considering the above. I wish the committee all the best in their decision making process.

Yours Sincerely,

Emma Gallagher
Provisional Psychologist