

Commonwealth Funding and Administration of Mental Health Services

My submission relates to the particular benefits of funding clinical psychologists to provide mental health services through the Better Access to Mental Health (BAMH) Program. Not unlike specialist medical practitioners (e.g. psychiatrists), clinical psychologists are uniquely qualified in their field of expertise as is recognised in the current two-tiered system referred to in item (e) of the Terms of Reference. My submission is that this two-tiered system should be retained, or even enhanced, to recognise the specialist training and skills offered by clinical psychologists.

Clinical psychologists are specialist psychologists who have undergone rigorous academic and skills based training over the course of a two year masters degree, following completion of a 4 year generalist psychology degree. Through this process, clinical psychologists develop advanced competence in evidence-based assessment (including complex diagnosis), case formulation, psychotherapy, evaluation, research, and treatment methodologies. These skills are directly transferable to the provision of highly skilled interventions for patients referred under the BAMH Scheme.

There is usually a rigorous selection process carried out by universities before undergraduates can be admitted to a masters degree in clinical psychology. For example, in my case, selection was confined to those candidates who had obtained first or second class honours in their undergraduate psychology degree and who were further selected through an interview process. On completion of the masters degree (at least 6 years of university study in total), a further 1-2 years of supervised practical experience is required before they are officially endorsed as clinical psychologists. This compares to registered psychologists who have completed only the 4 year generalist degree followed by a two year period of supervised experience in order to achieve registration.

It should be noted that the undergraduate psychology degree is currently purely theoretically-based. For registered psychologists, skills acquisition takes place in a fairly ad-hoc way during the two year period of supervised practice. By comparison, skills-based learning and practice under the auspices of experienced specialist clinical psychologists is integrated into the clinical masters degree. I emphasise this point because there are currently even many registered psychologists who do not recognise the qualitatively different training and skills set of the clinical psychologist versus the generalist psychologist. Having been first a registered psychologist of several years standing before undertaking the post-graduate clinical masters degree, I am in a position to recognise that there is a vast difference between the two. In the same way, registered psychologists are recognised as having qualitatively enhanced skills and knowledge in the treatment of mental health disorders compared to social workers or occupational therapists.

Apart from psychiatrists, clinical psychologists are unique in the advanced skills that they can bring to the assessment and treatment of mental health disorders. While some generalist psychologists develop more complex skills during the course of their work and ongoing professional development, clinical psychologists are the only allied health professionals who follow a structured program of skills and knowledge development in the assessment and treatment of mental health disorders. This advanced competence needs to be recognised by a tiered remuneration system which differentiates the generalist psychologist from the specialist clinical psychologist.

I further submit that the proposed reduction in the number of sessions to be funded per patient under the BAMH Scheme (item (b) in the terms of reference) will be detrimental to those who need the most help. Ten sessions may be adequate for those with less complex needs but it would be extremely detrimental to limit the sessions in this way for those with more complex needs. Part of the treatment process involves a period of engagement between the therapist and patient during which the therapist becomes familiar with the patient's history and presenting concerns. In complex cases, it may take several sessions for this part of the process to occur. Having fewer sessions may be counter-productive as the patient may have

to engage repeatedly in different years with different therapists. A more streamlined system would provide continuity of care which can be very important in the treatment of severe mental health disorders.

Clinical psychologists are especially well qualified to determine the therapeutic needs of presenting patients and would be well qualified to use their discretion as to which patients may need a longer period of therapy. Over the time that I have been providing mental health services under the BAMH model, I have received a variety of referrals from general practitioners. In some cases, I have determined that the patient needs only a few sessions to return to more normal functioning. However, I have also had referrals in which the patient clearly needs a more extended treatment period (in some cases up to the maximum of 18 sessions currently provided) in order to achieve stability. In several cases, the referred patients were sole parents whose children were directly impacted on by the mental health problems of the parent. To terminate therapy at an arbitrary 10 session limit has the potential for disastrous consequences for more than just the referred patient.

While there are always limitations on the funding available for health care, it seems clear that there are far-reaching benefits derived from funding of mental health services through the Better Access to Mental Health Care scheme. The strong take-up of this program proves its value to the Australian population. It is usually not only the referred patient who derives benefit from mental health care services. For example, providing mental health services for parents of young children can help to provide more stability for the children as well. In fact, another limitation of the current system is that the referred patient must be present for therapy. In the case of children, it can be more beneficial to see the parents or carers instead of the referred child and to direct therapeutic input at the parent level.

In sum, I submit that the advanced skills of clinical psychologists are uniquely suited for the provision of mental health assessment and treatment services and that this should continue to be recognised by a tiered remuneration model. I also submit that limiting treatment to 10 sessions would be potentially detrimental and that discretion to provide up to 18 sessions per patient per calendar year should be granted to clinical psychologists.