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

We are three clinical psychologists making this submission together. Nina and Alex work in the child and adolescent public mental health system part-time based in (North of Adelaide), and part-time in a private practice at . Kathy divides her time between Royal Park in private practice, and a large General Practice setting located in , also in Adelaide's North. All of us have deliberately chosen to work in areas of high socio-economic advantage where there is the greatest need for our professional skills and an inadequate number of affordable, accessible psychological service providers.

We are commenting on two issues: (1) the rationalisation of the number of allied health treatment services from a maximum of 18 to 10, and (2) the two-tiered Medicare system rebate.

1. Terms of reference B(ii)and B(iv): The rationalisation of allied health treatment sessions and the impact of changes to the number of allied mental health treatment services for patients with mild or moderate mental illness under the Medicare Benefits Schedule

We have combined our responses to these two items because we believe severity cannot be assessed at the point of referral by a GP and that a system devised on the basis of this distinction is flawed. Our training equips us to do an initial and ongoing assessment of psychopathology. It is our understanding that GPs do not have the time or the specialist mental health training to make these kinds of in-depth assessments, as illustrated in some of the case studies on page 4.

We argue that the restriction of client sessions as proposed will have negative consequences for clients. In our practice, approximately 15 – 20 % have required more than 12 sessions.

Of those who have required more than 12 sessions:

- Some have had major mental illness (including co-morbid substance use, mood disorder, personality disorder) that has required extended sessions to identify and treat (see case study 1, p.4). Some have presented with less severe mental illness, but have been ready and able to address longstanding health and wellbeing issues with significant impact on their capacity to positively contribute to society (see case study 2, p. 4). Some have required a longer treatment because their mental health problem is connected to a major life event where the impact is ongoing (see case study 3, p. 4).
- None of these people would have met the criteria for a service through public mental health services and none of them would have been able to afford private psychological care. If we were not funded to see these clients for the number of sessions required to ameliorate their difficulties, they would not have received an adequate service for their needs.

2. Term of reference E(i): The two-tiered Medicare rebate system for psychologists

We argue that all psychologists with a Masters or higher degree have the necessary psychological training to equip them to administer Focused Psychological Strategies, compared to the other disciplines that do not have the same level of dedicated in-depth training in psychological theories of brain and behaviour.

Thus, we believe that the $119.80 rebate should be made available for all registered psychologists who have completed a Masters or higher degree. This would recognise not only the additional training, but also the additional professional development requirements, supervision requirements and ongoing costs of registration for psychologists to practice, as opposed to other disciplines who do not have these same professional impositions.

With respect to Clinical Psychologists, we argue that the additional training undertaken should be recognised with higher rebates (e.g. $150) for the following reasons:

- Psychologists who meet current criteria for membership of the APS College of Clinical Psychologists require **6 years** of tertiary education, including 2 years of specialist tertiary education in clinical psychology plus **80 hours** (commonly spread across 2 years) of additional one-on-one supervision by a member of the College of Clinical Psychologists in the APS. In other words, to become a clinical psychologist requires a minimum of **8 years** of training and supervision. This is specialist training in the identification and treatment of mental health issues, which is the task required of people administering Clinical Psychological Therapy items. This is far more in-depth and focused training compared to a person who has done two years of workplace supervision after their 4th year (Honours in Psychology). Firstly, the 4 undergraduate years of psychology (including Honours) provide a broad grounding in psychological theory but there is minimal exposure to psychopathology (the domain of clinical psychology) in the course content. That material is the exclusive focus of the Masters in Clinical Psychology curriculum. Secondly, for a person who takes the 4 + 2 option to become a registered psychologist (i.e. not the Masters degree), those additional 2 years of supervision within a workplace cannot be reliably demonstrated to have given the person the same breadth of exposure to different clinical problems as someone who has done the 3 clinical placements required in a 2 years Master's course, plus the 80 hours of one-on-one clinical supervision to join the College of Clinical Psychologists, which specifically requires the candidate to cover a wide range of clinical problems in all the major diagnostic categories before they can be admitted.
- Research shows that the treatments clinical psychology brings to mental health are in many cases more effective than medication, while currently psychiatrists are rebated at a higher rate.
- Our extensive education has come at great personal cost: both the fees associated with postgraduate education and the amount of time out of full time workforce to train in the higher degree. If this additional training and specialist knowledge is not financially recognised this will deter others from engaging in this higher level training, reducing the accessibility of highly skilled professionals to the public. Psychologists without postgraduate education have not been required to make this same degree of sacrifice in the pursuit of higher levels of education and training and this would be unrecognised should the two-tier system be abolished.
- Psychologists who have completed a Masters or PhD have additional demonstrated skills in interpreting and producing high quality research. The three of us have all completed PhDs in clinical psychology, and our research contributions include

influencing how children are interviewed about child abuse, emotion regulation in adolescence, and treatment options for children and young people in foster care.

- We also believe that individuals who have completed Masters with a Forensic specialty have adequate training in psychopathology assessment and intervention and should be able to access this higher rebate also. Their work also entails working with people with highly complex co-morbidity.

Dr Nina Cook - B.Psych (Hons), D.Psych (Clinical – Child Specialisation), CClin

Dr Alexandra Osborn - B.HSc (Hons), MPsych (Clinical), PhD, MAPS, CClin

Dr Kathy Fogarty – B.Arts (Hons. Psych), M.Psych (Clinical)/PhD, MAPS

25 July 2011

Case 1: Complex co-morbidity in our case-load – severe, undiagnosed mental illness and substance dependence

Since October 2010, Kathy has been treating a 55 year-old man who was initially referred by his GP with long-standing depression and substance dependence (alcohol). He had had many hospital admissions over the past 10 years due to alcohol withdrawal and frequent strong suicidal urges. Over several sessions, Kathy was able to observe the shifts in his mood across sessions that led her to suspect an underlying bipolar disorder, which she communicated to the GP. The GP was sceptical but agreed to make a referral to a psychiatrist specialising in mood disorders. The psychiatrist confirmed the diagnosis, and the man is now being properly treated. With a more stable mood, treatment for his alcohol addiction is much more successful, he is living independently, and he is regaining his ability to earn income as an artist.

Case 2: Complex co-morbidity in our case-load – the importance of therapeutic alliance in building readiness to change

Nina has been treating a 45 year-old man with an extensive forensic and substance abuse history who initially presented with mild depression. He required 10 sessions to build trust in the therapeutic relationship but has now been able to consider returning to work, has remained abstinent from alcohol and has not offended during the period of treatment.

Case 3: Complex co-morbidity in our case-load – mental health and major life events

Kathy has been treating a 48 year-old woman who was initially referred with anxiety and depression. After 3 sessions focused on treatment for depression and anxiety, the woman disclosed that she was in a severe domestic violence situation, where she was being subjected to physical, emotional and financial abuse, including isolating her from her family. The focus of therapy changed to psycho-education on the cycle of violence, and cognitive-behaviour therapy to target the woman's core beliefs about herself, her worth and her future. She has since left the relationship, is living independently, has restored all her family relationships and is feeling extremely happy and hopeful. The depression and anxiety have completely remitted. However, the perpetrator remains in the background making occasional intrusions into her life, and so she wants to continue coming once a month to review how she is going, and to re-inforce the new learning that has taken place in therapy.