

My name is Mai Dao and I am a Clinical Psychologist working in Adelaide, South Australia. I completed my Master's in Clinical Psychology in 2009 and upon graduation have been working for the South Australian Health Department as a Clinical Psychologist in several roles- working in a psychiatric inpatient unit, a community mental health crisis and intervention service, a community psychology clinic as well as in private psychology in a medical centre. As such, I have experience working with clients with a wide range of severity as well as have exposure to the public mental health system and private system. I would like to raise my concerns regarding some proposed changes to the Better Access Initiative in mental health in the Government's 2011-2012 Budget.

(b) changes to the Better Access Initiative, including:

(i) the rationalisation of general practitioner (GP) mental health services,

(ii) the rationalisation of allied health treatment sessions,

(iii) the impact of changes to the Medicare rebates and the two-tiered rebate structure for clinical assessment and preparation of a care plan by GPs, and

(iv) 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;

Firstly, the proposal that the two tiered rebate structure be reduced to one is of great concern. In order to become a Clinical Psychologist, individuals must be placed at the top of their cohort in their tertiary psychology studies to receive a position in the highly competitive clinical masters programs. The two year specialised training in clinical psychology trains individuals to develop highly specialised skills and knowledge in the area of mental illness, psychological assessment, therapy and research and exposes them to mental health clients from mild to severe conditions via three placements. Upon completion of the program, these psychologists must devote a significant amount of their time to ongoing clinical supervision as well as clinical psychology specific professional development in order to be endorsed as a clinical psychologist (totalling 8 years). Indeed 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.

The expertise that clinically trained psychologists possess is well regarded and although I am unaware of how other interstate government departments operate, in the South Australian Mental Health system, only clinically trained psychologists are eligible to apply for positions and specialised knowledge and skills in evidence based psychological assessment, therapy and research is assumed as a result of their masters training. Furthermore, the mental health service only provides supervised placements to those enrolled in a clinical masters degree. Clinical Psychologists are also 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.

The reduction of a two tiered system to one tier is concerning as it doesn't distinguish the difference between psychologists who have received basic training in general psychological strategies to those that have more advanced training and skills. If general and Clinical Psychologists are rebated the same it does not distinguish to client, GP or general public that there is much difference in the two types of psychologists, which could lead to both

inappropriate referrals to those not as well trained, underutilisation of the expertise of Clinical Psychologists which would decrease the ability for clients to be provided quality treatment. When consulting a private Clinical Psychologist it is a given that at some stage in their career they have had experience in working with a range of mental health conditions from mild to severe through their placements at university to possible work in the public mental health service. However when consulting a general psychologist it is not a given that they have had such exposure.

Indeed the **Work Vale Case, Western Australia 2001** differentiated the complexity of psychological interventions in three levels:

Level 1- "Basic" Psychology - activities such as establishing, maintaining and supporting relationships; use of simple techniques (relaxation, counselling, stress management)

Level 2- Undertaking circumscribed psychological activities (e.g. behavioural modification). These activities may be described by protocol

Level 3- Activities which require specialist psychological intervention, in circumstances where there are deep-rooted underlying influences, or which call for the discretionary capacity to draw on a multiple theoretical base, to devise an individually tailored strategy for a complex presenting problem. Flexibility to adapt and combine approaches is the key to competence at this level which comes from a broad, thorough and sophisticated understanding of the various psychological theories.

The group suggested that almost all health care professionals use level 1 and 2 skills and some have well developed specialist training in level 2 activities. The group went on to argue that Clinical Psychologists are the only professionals who operated at all three levels, "it is the skills required for level 3 activities, entailing flexible and generic knowledge and application of psychology, which distinguishes clinical psychologists...".

As such, I would strongly advocate that significant consideration be given to adhering to the current two tiered system and that the level of quality of client care remains the highest priority when making these decisions.

Secondly, I urge that the number of rebated treatment sessions be considered. When looking at best practice guidelines for various evidence-based psychological therapies the minimum number of treatment sessions for these interventions is 12 sessions. Within these studies, participants are already screened out of the study if they have co-morbid conditions, personality issues, consume alcohol or drugs, are of certain cultural and linguistic backgrounds and so on. Clients in the community typically do not reflect the populations that volunteer themselves to participate in such studies and it is certainly rare in public and private settings for clients to not have co-morbid conditions, personality issues, consume alcohol or drugs, are of certain cultural and linguistic backgrounds and often require more than the 12 sessions commonly suggested. By reducing the number of rebated sessions, there is concern that clients will not be adequately assessed (due to insufficient rebated sessions), which is a crucial part of intervention because from a case conceptualisation and treatment plan can be created which guides the remainder of therapy. Many clients, if requiring additional sessions will simply be unable to afford sessions which would leave their treatment incomplete. The argument that moderate to complex severity clients should be referred to the public mental health system or the ATAPS programs is flawed. In my position in the acute stream of public

mental health services, a large part of my role is arranging psychological follow-up in the community for patients who have come into crisis or are being discharged from a psychiatric inpatient unit. While there is a public mental health psychology clinic, we simply do not have the resources to provide services to a large number of clients and I refer a large proportion of clients to private psychologists under the Better Access Scheme and some to the ATAPS program. If all moderate to severely complex clients were referred to ATAPS rather than being managed under better Access, I strongly doubt that the service would be able to manage all the referrals and it would not be too long before waiting lists occur which does not provide the community with quality psychological care.

When reviewing the Better Access Scheme for the purposes of managing the Government budget, I strongly urge that you consider what the research has found about the differences between general and Clinical Psychologist in Australia but also internationally (United States, United Kingdom and Canada in particular) and also the guidelines regarding suggested number of treatment sessions in the guidelines regarding evidence based psychological interventions (e.g. the NICE guidelines).

Yours Sincerely,

Mai Dao
Clinical Psychologist