



Ivan Raymond
Clinical Psychologist

Consulting Locations:

Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600
Australia

M:
F:
E:
W: www.connectedself.com.au

August 5, 2011

To whom it may concern,

**RE: Submission to Community Affairs References Committee:
Commonwealth Funding and Administration of Mental Health Services**

I submit this submission to the Community Affairs Reference Committee in reference to the Community Funding and Administration of Mental Health Services.

The contents of this submission are drawn from my experience and knowledge providing clinical psychology services to children, adolescents and adults under a range of federally funded mental health initiatives and programs. This includes:

- Provision of three years of clinical psychology services under the ATAPS program in the regional location of Port Lincoln;
- Provision of three years of contracted clinical psychology services to the regionally based Murray Bridge Headspace location, with the work funded under the Medicare Better Access program.
- Provision of clinical psychology services under the Medicare Better Access program to metropolitan South Australian children, adolescents and adults.
- Two year training and supervision of trainee psychologist for Registration purposes.

Furthermore, I am one of seven specialist trainers for Headspace (Youth Mental Health Agency), and have travelled to a large number of Australian Headspace sites providing specialist training packages.

I have undertaken post-graduate study in clinical psychology and have undergone further training to supervise provisional psychologists.

In acknowledgement of the aforementioned, I feel suitably experienced to respond to the following points within the Terms of Reference:

(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

There are wide discrepancies in the quality of care plans prepared by GP's. From my experience, approximately 40% of the care plans are sufficiently detailed to add significant utility to the clinical assessment process and aid robust care planning. Meanwhile, approximately 30% of the care plans offer insufficient detail thereby offer minimal practical utility to the clinical assessment process, and the remaining care plans offer no utility within the mental health care planning process owing to their lack of sophistication and/or detail.

Opinion: Greater accountability of care planning is warranted, with there being strong grounds for the proposed rationalisation of this health service to drive broader efficiencies.

(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;

Under the Better Access program psychological support has become infinitely more accessible to individuals who would not otherwise be able to afford to pay for these services, or whose issues or circumstances precluded them from accessing an overextended public system. This has included improving service delivery and accessibility to the most vulnerable groups in our society including children and adolescents, the elderly, those with a disability, and those from culturally and linguistically diverse backgrounds. The government's investment in mental health is welcome.

The Medicare system has enabled me to provide a service to disengaged children and young people in regional Adelaide at no cost to themselves or their families. These young people are disengaged from mainstream schooling, have complex family and social issues (e.g., history of trauma, homelessness, familial dysfunction, drug and alcohol use, engagement in offending behaviour) and frequently meet the criteria for more than one mental health condition (e.g. ADHD, Aspergers Disorder, Anxiety, Depression, Posttraumatic Stress Disorder). Frequently the level of apparent risk to self or others is high and there is very often a history of aggression, self harming and suicidal behaviour. The prognosis for these young people without intervention is poor and as adults they are disproportionate consumers of social welfare resources.

Obviously the client group described above represents the more severe end of the spectrum where a reduction in services is likely to have the most impact. This is because generally speaking, the more complex and severe the presenting issues, the more sessions are required. Clients presenting with mild mental health concerns would be typically discharged within the existing 12 sessions, if not well before, hence are unlikely to be affected by the proposed cuts. In contrast, these cuts will have a significant impact on clients within the moderate to severe end of the spectrum. At present, this client group is not always adequately serviced within the full 18 sessions however this goes significantly further towards meeting their needs.

Should services be reduced for these clients, they are increasingly likely to be discharged before issues are resolved or stability is attained, unless they are able to privately fund

ongoing sessions. Unfortunately for the majority of this group, this is unlikely to be an option. Providing a partial or incomplete service which is driven by resource rather than consumer need is contradictory to best practice principles and will inevitably produce significantly higher levels of relapse and poorer overall outcomes for these clients.

There is an argument that clients requiring more long term or intensive intervention may have increased access to other bodies of funding and services, hence reducing the need for clients with severe mental health issues to be seen by Better Access psychologists. Whilst I applaud this initiative to provide increased mental health services within the public and non-government sector, as it stands the public system is also significantly under resourced and over utilised and even with proposed changes (e.g., expansion of ATAPS and Medicare Locals) the public system is highly unlikely to be able to bridge the gap between demand and supply.

Both previous and current governments need to be supported in their development and endorsement of the Headspace model. This is one of the most innovative and evidence-informed developments in mental health in recent years. This model provides the means to provide targeted support to children and young people through a "soft entry" point. A feature of working with children and young people is that there is a need to consult with a variety of stakeholders (family, teachers, brother, sister, youth worker) to inform the assessment process. At present, this requires these family members to attend the appointment with the young person. Unlike an adult where an assessment is likely to be completed after 1-2 sessions, for children and young people, it often takes 3-4 sessions to conduct the assessment. Furthermore, the intervention involves separate discussion and/or intervention with the child, family member, teacher and youth worker. Therefore, to conduct a holistic or evidence-based intervention with a child and adolescent, there are greater resource and time implications which needs to be considered within the number of sessions available for intervention. There is a strong argument that if the government wishes to invest in early intervention (e.g., Headspace), as supported within the academic literature, they need to resource these institutions in a manner promoting evidence informed assessment and intervention.

Opinion:

- While acknowledging the need to rationalise current services, it is suggested that the exceptional circumstances clause should be re-introduced to allow clients to access an additional 6 sessions of support (above the current figure of 10), where clinically assessed and indicated through a GP assessment process.
- Children and young people under the age of 25 years of age, should be provided the opportunity to access up to 18 sessions of targeted intervention under a MHTP, where clinically indicated through a GP assessment process, with this being extended to 24 sessions under the exceptional circumstances clause. Up to six of these sessions should be made available for the psychologist to conduct assessment and intervention with family members, youth workers, teachers or significant adults in the child's or adolescent's life.

(i) the two-tiered Medicare rebate system for psychologists,

The profession of psychology is a heterogeneous discipline, and there are wide differences between psychologists in terms of experience, skills and competence, in particular as it relates to clinical mental health provision. Psychologists specialise in areas as diverse as mental health, organisational change, forensic issues and spirituality. All Registered Psychologists have foundational skills to provide targeted support to individuals with mental health conditions. However, within the discipline there are wide differences in a psychologist's capacity to provide more intensive and evidence informed clinical intervention, especially with clients with moderately severe conditions, comorbid mental health conditions (e.g., two or more mental health conditions) and with children and adolescents.

As a clinically trained psychologist I have undertaken Masters level study and training to conduct specialist assessment and intervention techniques. This provision included a course on "Child Psychology" which provides specialist training on working with children and adolescents. Children and adolescents present with distinct mental health needs, which requires the psychologist to assess the child, their family, the relationships between family members and the developmental history of the child. At present, clinically trained psychologists are the only specialist psychology stream who receives formal clinical training in this area. The provision of evidence informed and ethical services to children and young people requires higher level training and skills. At present, a very high proportion of psychologists with non-clinical degrees do not have the skills or abilities to provide such services to children and young people. Without a two-tiered system, the public have no ability to discern a psychologist's background training or capacity to provide such intervention. The two-tiered system fosters an ethical and accountable mental health system, notably for minority or vulnerable client groups such as children.

Recently, the government has reinforced and extended its commitment to the Headspace, youth mental health model. This model has a strong reliance on appropriately qualified and trained psychologists providing services to children and adolescents. Within this system there is a strong need to differentiate a psychologist's capacity to implement more sophisticated assessment and intervention strategies for this vulnerable group. While it is acknowledged that through specialist training and development a non-clinically trained psychologist may be competent to provide services to children, the two-tiered system provides the incentive and accountability mechanisms to drive the Headspace program to an evidence-informed model.

In addition to the points noted, the two tiered Medicare rebate system for psychologists was implemented in recognition of differential skills level of psychologists with respect to the provision of clinical services, with the higher level of rebate being available to clinical psychologists. Hence the system differentiates between clinical and generalist services. It is akin to a system which differentiates between a general practitioner and a heart specialist. For some clients, a general practitioner is more than equipped to meet their health care needs, whereas for others a heart specialist is required.

At present the higher level of rebate provides an incentive for psychologists to undergo the rigorous training required to attain and maintain clinical status. I anticipate that fewer psychologists would seek to do this if there were no financial gain. This would result in decreased accessibility to specialist services to clients in need.

In terms of the rebate itself, the current national recommended hourly fee for psychologists is \$218.00. The current scheduled fee for the lowest rebate tier is \$81.60 and the highest \$119.80. This fee is charged for the face to face contact time with the client and does not cover the many additional services involved such as case noting, writing reports, liaising with other services such as schools, case managers, families, crisis intervention etc. Currently I charge well below the national recommended fee, offering bulk billing services for disadvantaged clients and charging fee paying clients only a small gap. Should the rebate be reduced, I would no longer be in a position to offer a bulk billing service and the gap for fee paying clients would almost double. This would significantly reduce affordability for many clients and would essentially exclude the majority of low income earners from accessing my service.

It is my current opinion that clinically trained psychologists is a speciality area within psychology whose skills align to the highest Medicare benefit level. Clinical psychologists specialise in the assessment, diagnosis, evidence-based treatment and treatment outcome evaluation of mental health disorders across the lifespan at all levels of complexity and severity. Along with psychiatry, clinical psychology is the only specialist training in which the entire post-graduate program is in the area of mental health. This training ensures that clinical psychologists are trained to an appropriate level to provide clinical services under the Medicare Better Access scheme.

There is significant and heated debate in the psychology field about the degree the two-tiered system has split "clinically psychologists" and "other psychologists". Unfortunately "clinical psychologists" have been provided derogatory labels such as "superior" by non-clinically trained psychologists who wish to express their frustrations within the current process. This has been an unhelpful distraction to an important debate. It is worth noting however that both the public and fellow professionals can have a high degree of confidence that a "clinical psychologist" has the skills and abilities to apply advanced therapeutic assessment and intervention. Conversely, both the public and other professionals cannot be as confident with the degree a psychologist with a non-clinical qualification (or non-Masters study) has specialist knowledge and skills in clinical mental health. This does not however preclude them from being equipped to provide clinical services, and there is good reason to articulate and implement a sound system of assessment and accreditation to ensure that there is a clear pathway towards clinical service provision for other psychologists. I have received evidence from generalist psychologists that, historically, there has not been a clear and transparent accreditation process by which psychologists with non-clinical Masters degrees can (1) demonstrate their capacity to provide clinical psychology services or (2) undertake training, development and supervision to demonstrate their capacity to provide clinical services. Rightfully so, this remains a significant source of stress for these professionals which has recently bubbled over within the current debate. Based upon the evidence presented before me, it is my opinion that an external review of the assessment process for Medicare clinical accreditation should be undertaken.

Opinion:

- To ensure the continuation of an evidence-informed, progressive and ethically sound mental health system, the two-tiered system should be maintained.

- In light of the current disquiet, an independent review of the process by which psychologists qualify for highest level of the two-tier system should be conducted.

(f) the adequacy of mental health funding and services for disadvantaged groups, including:

(i) culturally and linguistically diverse communities,

(ii) Indigenous communities, and

(iii) people with disabilities;

(g) the delivery of a national mental health commission; and

(h) the impact of online services for people with a mental illness, with particular regard to those living in rural and remote locations and other hard to reach groups; and

(j) any other related matter.

I currently provide clinical psychology provision to clients of low SES backgrounds within rural South Australia, including children and young people, and Indigenous clients. This provision is provided under the Medicare Better Access Scheme. As part of the contracted arrangement with local Divisions of General Practice, I am currently providing a bulk-billed service. Within these areas, the bulk-billing nature of the work has significantly increased the accessibility of services. The vast majority of clients would not access a service if there was a gap payment. As a psychologist working in such areas, it would not be viable for me to provide such services unless I was reimbursed for travel allowance, and paid a small retaining wage that compensates for clients who do not attend appointments.

At present, within both Port Lincoln and Murray Bridge, the demand for services is currently outstripping the availability of practitioners to provide such services. The federally delivered money through the Divisions of General Practice (ATAPS) has provided significant capacity building in both areas. One notable concern with such provision is that the Divisions of General Practice are becoming "mini mental health agencies" and from my experience, they lack the clinical governance, procedures and processes to manage the high level of risk they currently carry.

Headspace is one of the shining lights of the Australian mental health system. Mental health problems are overrepresented within the burden of disease experienced by young people, and most concerning, without intervention this burden of disease and associated costs is likely to transition across the individual's adult life span. Young people are notoriously hard to engage in mental health services and a feature of the Headspace model is that it offers a "soft entry" point for young people to access trained professionals. That is, young people are engaged and triaged by youth workers who can then work with on-site GP's and make recommendations about future psychological intervention. When this triaging process is done well, it represents an excellent cost rationalisation process as only the neediest client accesses a more expensive psychiatric/psychological intervention.

Opinion:

- The ATAPS program should receive ongoing funding and support.
- Further expansion of the Headspace model should be strongly considered.
- Incentives (e.g., travel allowance, reimbursement for clients who do not attend) need to be provided to psychologists who work in rural areas to enable them to maintain a viable practice, notably when they provide bulk-billing psychological services.
- Medicare Locals who deliver mental health services need to be funded to implement appropriate clinical guidance, governance and processes to manage the high levels of associated risk.

I am happy to elaborate further on any aspect of this submission.

Sincerely,

Ivan Raymond

B.S.Sc., B.Psych.(Hons), M.Psych(Clinical)