28 July 2011

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

Dear Madam/Sir,

SENT BY EMAIL community.affairs.sen@aph.gov.au

Re: Senate Committee Enquiry into Community Funding and Administration of Mental Health Services

I am writing to address two specific issues of grave concern as outlined in TOR b iv (regarding the number of allowable sessions for clients to access clinical psychology services under the Better Access initiative) and TOR e i (regarding the review of the two tiered system of Medicare rebates for generalist versus clinical psychologists).

In relation to TOR b iv, the Federal government plans to cut the annual maximum allowance of sessions from 18-10 with no exceptional circumstances enabling additional sessions. The rationale for cuts is that *the Better Access initiative will be "more efficient and better targeted" by "limiting the number of services that patients with mild or moderate mental illness can receive..." In my understanding of the available data, 13% of clients seen under the Better Access scheme used more than 10 sessions. In their audit of 9,900* clients seen for more than 10 sessions of treatment, the APS found that 80% of clients who required more than 10 sessions of psychological treatment had moderate to severe high prevalence mental health disorder including depression and anxiety disorders. Only a very small number had a low prevalence disorder (3.0% had a psychotic disorder and 4.5% had a diagnosis of bipolar disorder). On referral of those who required more than 10 sessions, 83.6% were rated by the

treating psychologist as having a moderate to severe (40.5%) or severe presentation (43.1%) and only 0.2% were rated as having a mild presentation. 42.5% had complex presentations with co-morbidity involving another ICD-10 mental disorder, drug and/or alcohol abuse or a personality disorder. At the conclusion of the episode of treatment, **42.6%** were rated by the treating psychologist as having no residual symptoms (10.2%**)** or a mild presentation (32.4%), while only 2.5% retained a severe presentation. This data shows that these clients who are using up to 18 annual sessions have moderate to severe levels of high prevalence psychological disorders as was intended by the Better Outcomes programme. It also shows that these clients benefit from the extra sessions such that many have completely recovered by the end of treatment.

The government recommendation goes on to state that "patients with advanced mental illness" will be "provided with more appropriate treatment through programs such as the Government's Access to Allied Psychological Services program" or be seen in the public system. The ATAPS program run through the Divisions of General Practice (DGPs) is not a viable referral option under current arrangements. There is insufficient funding in ATAPS to provide services for anything like the number of 260,000 people (or 86,000 per annum). A major issue is that a significant proportion of the funding for mental health services received by DGPs is spent on administration rather than providing funding to the psychologists who are engaged to deliver the services. As a result, frequently more junior psychologists are selected to provide services and more experienced psychologists cannot viably undertake the work. The Government's own evaluation of Better Access demonstrated that it is a cost-effective way of delivering mental health care. The typical cost of a package of care delivered by a psychologist under the initiative is $753, significantly less than ATAPS which costs from two to 10 times that of Better Access per session.

*In addition, t*he vast majority of clients currently obtaining more than 10 Better Access sessions would be denied access to public sector mental health services because they have high prevalence disorders, rather than chronic, long-term problems such as schizophrenia or Bipolar Disorder and as such, are not necessarily in need of team-based care. Moreover, the recommendation that these people should be referred to a consultant psychiatrist is not realistic as there is a significant shortage of psychiatrists and anecdotally most charge a prohibitive gap fee in the range of $200 per session. Moreover, psychiatrists are better used

in treating low prevalence disorders requiring medication and overseeing of treatment in highly complex and co-morbid conditions rather than in treating high prevalence disorders with psychotherapy. In sum, the available data confirm that the Better Access initiative is providing effective treatment for the people it was designed to treat – those with high prevalence disorders.

In my clinical experience the clients who need more than 12 sessions are those with significant and severe clinical symptomatologies who would otherwise have been unable to access a clinical psychology service and who have benefitted greatly from additional treatment. Some would have benefited from more than 18 sessions. It is true that some would have benefited from 50 annual sessions and some of my clients have needed to fund additional sessions to continue treatment until recovery from such severe psychological conditions such as Borderline Personality Disorders was complete. To consider reducing the number of available rebatable sessions would reduce the success and the accessibility of the program. I recommend therefore, that the decision to cut the number of rebatable sessions from 18 to 10 be reversed immediately.

I would now like to address the issue as outlined in TOR e i regarding the review of the two tiered system of Medicare rebates for psychologists. When first introduced, the government worked very closely with the main representative body of psychologists (The Australian Psychological Society) to determine that given the clinical nature of the work undertaken in the Medicare scheme (as eligibility requires clients to have a DSM-IV diagnosable mental health condition) that it was appropriate to rebate those who possessed specialised clinical psychology qualifications, at a greater rate than those psychologists who have chosen not to achieve those same qualifications, or whom work under a different, non clinical, speciality, such as sports psychologists or organisational psychologists. The specialty of clinical psychology has long been recognised; as early as 1997 Western Australian psychologists presented and won a case to the industrial relations commission regarding the need for clinically trained psychologists to be acknowledged due to their specialised skills and abilities that comes from the advanced, specialised training.

At the current time there are nine specialisations in psychology, all of which need to be recognised by the professional body of psychology as having distinct intrinsic skills. Clinical psychology is the only one of these specialities in psychology, and the only profession apart

from psychiatry whose entire accredited and integrated postgraduate training is specifically in the field of lifespan and advanced evidence based psychopathology assessment, diagnosis, case formulation, psychotherapy, evaluation and research across the full range of severity and complexity of mental health disorders. Clinical Psychology requires a minimum of eight years training. Clinical psychologists are 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 unique specialisation of clinical psychologists has also been recognised overseas in countries such as Great Britain and the US, where only those with accredited postgraduate qualifications in clinical psychology can practice as psychologists. In addition, the current government requirement for clinical psychologists to complete additional hours of professional development in order to retain specialist registration as a psychologist has further validated the profession of psychology as being as uniquely and distinctly valuable as psychiatry is to medicine. How then, can this government consider it appropriate to de-value and deskill the profession of psychology by not only removing the acknowledgement of the specialised skills and abilities of specialist clinical psychologists, but by essentially making a decision which would deem (for example) that the specialist skills of a sports psychologists can be generalised to treating clients with complex and severe mental illness. This would imply that the non-clinically trained sports psychologist is as competent and skilled as that of the 8 year trained clinical psychologist who has worked exclusively with individuals, families and groups of people with mild, moderate and severe mental illness. The removal of the two tiered system would remove any accountability of requirements of training and therefore place clients at possible risk. In my opinion, this proposal is akin saving the Government money by removing all medical specialities and having GP's undertake all kinds of medical procedures from orthopaedic surgery to psychiatric evaluations and treatment. Australia will be unable to retain its highly trained and skilled clinical psychology workforce if the profession is no longer regarded as being experts in the field.

Overall, only those psychologists who are trained specifically in the specialised area of clinical psychology possess the unique skills necessary to treat the most complex and severe of mental health presentations. Whilst there are many colleagues who have other specialist psychology qualifications such as counselling and sports psychology who have worked for many years treating people with mild mental illness, it is essential for the public and the

profession that we maintain the highest quality of care by ensuring that those psychologists who work with mentally ill persons are trained specifically in the area of clinical psychology. This is the only way that the gold standard of practice can be maintained. Removing the two tiered system will mean that the public will be unable to determine whether or not they are being treated by a specialist clinical or a generalist psychologist.

I thank the committee for the opportunity to put forward this submission, and I am available to make further comment or provide further information if required.

Yours sincerely

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