

Senate Community Affairs Committee

Inquiry into Commonwealth Funding and Administration of Mental Health Services

Terms of reference (a), (b) ii, iii, & iv through to (g) are addressed with particular emphasis on the Better Access program

Thank you for providing us with the opportunity to make a submission to this Senate Enquiry. We do not represent an organisation as such but the document represents the collective views of the four of us. All four of us are clinical psychologists and all four of us have worked in the state public mental health system or state hospital system. Three of us have undertaken part-time private practice in the past and only one of us continues to do so. Three of the four of us do not derive any income at all from BA. Currently, three of us are employed at the University of Melbourne.

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Better Access program: Background and Recommendations Summary

Although we fully support Medicare funding for mental health treatment services and were heartened by the establishment of Better Access (BA) in 2006, we wish to convey some serious concerns with the scheme's shortcomings, and propose specific improvements. The main shortcomings are the large number of providers without adequate standards of training in mental health, and the exclusive emphasis on service delivery via a private practice framework. Those and other issues requiring attention are elaborated in the following pages.

We believe it is not adequate for a national scheme such as BA to utilise providers who have not received appropriate clinical training in the treatment of mental health disorders. In fact, it was marked professional dissatisfaction with the original professional body, the APS, continuing to support access to provider numbers for members with no postgraduate clinical training that led to

formation of a new national professional body solely for clinical psychologists with appropriate postgraduate qualifications in 2010 (ACPA: www.acpa.org.au).

There has been no significant reform of BA to date, and such is warranted. We welcome the media comments by the Expert Group (Sunday Age, 20.03.11) that highlight for the public and the consumer the need for restructuring of the program, and hence write to inform the Community Affairs Committee of our views. However, the reform of cut back to individual session numbers to 10 needs reversing, regardless of the current private practice service format, since more input is commonly required with diagnosed mental health disorders.

We believe that the majority of funding in BA should be directed to centre-based, multidisciplinary team services from salaried staff. These can provide better coordination and integration of various services for non-psychotic mental health clients and more manageable ongoing costs. This service platform also assists an important and required greater focus on more complex cases, on collaboration to meet a range of client service needs (e.g., vocation or housing), and with prevention and early intervention in mental health - all of vital concern.

The recent evaluation of BA did not proceed according to scientifically accepted methods, the latter crucial for establishing the most accurate results. We believe the conclusions drawn are readily disputed based on the very poor methodology of the evaluation and therefore of limited value as a basis for decision-making going forward. As clinical practitioners and researchers with a strong interest in comprehensive and accurate data on interventions, we feel bound to point out the limitations of the evaluation, regardless of its favourable conclusions for the BA scheme and our own profession of clinical psychology. Details are contained in the body of our submission but two of us have an Editorial in press in a forthcoming issue of the Australian and New Zealand Journal of Psychiatry. A copy is attached as Attachment 1.

Recommendations

1. The recent evaluation of BA cannot be utilised for decision-making because it is fundamentally flawed. A properly constituted evaluation is required.
2. The requirement for professional mental health work is a recognised postgraduate qualification *and* formally supervised clinical experience. Providers without the required qualification need to be phased out and postgraduate training places increased to an adequate level.
3. MBS Allied Health Services Item "Focussed Psychological Strategies" (FPS) needs redefining correctly by removing listed functions that require postgraduate training. Remove the requirement for a GP Mental Health Plan in referrals to clinical psychologists, and similarly for other providers if appropriate.
4. Implement strategies to limit fees in private practice, such as fee caps or 100% rebates, particularly for low income clients, and establish an access cut-off for those with higher income.

5. Develop government-funded centre-based teams with salaried staff for improved affordability, equity of access, location of services where needs are greatest, and a more comprehensive, integrated service that is a better cost-effective alternative to private practice.
6. An increase rather than decrease in number of sessions per annum for clinical psychologists is required to allow sufficient and equitable access, especially for more complex clients. The Medicare sessions' allowance should be equivalent to psychiatry as both professions have specialist postgraduate training in psychotherapy.
7. Retain clients with serious mental health disorder within the BA program rather than transfer to ATAPS, except for those with psychosis managed by State mental health services.
8. Provide fully-funded postgraduate scholarships in clinical psychology tied to a subsequent period of work in underserved areas or with disadvantaged groups.
9. Undertake detailed investigation into the impact of Better Access on the clinical psychology workforce in state public mental health. Develop strategies to retain and augment clinical psychologists in the public sector, including postgraduate scholarships, as in 8 above.
10. Establish a National Mental Health Commission.
11. Provide increased focus on prevention and early intervention with funding increased or reallocated to younger age groups in order to reduce adults' needs for service over time.

Attached Documents (Documents are enclosed since these provide necessary detail for the points raised in the following summary:

- Attachment 1: Editorial by Allen and Jackson (2011) on Better Access, *Australian and New Zealand Journal of Psychiatry*, in press.
- Attachment 2. Victims tell of lives destroyed by abuse. *Sydney Morning Herald*, 19.07.11, p.5.

Key Issues

1. Critique of Report: "Evaluation of Better Access to Psychiatrists, Psychologists and GP's through the Medicare Benefits Schedule Initiative" (Pirkis et al., 2011)

Some would argue that any evaluation is better than no evaluation. We disagree. We believe that the conclusions drawn from poor quality evaluations can do enormous damage. Just because an evaluation is labelled an evaluation does not automatically mean it is a sound and high quality evaluation. We believe that the Better Access methodology described by Pirkis et al. (2011) is so flawed that only one sole conclusion can be drawn – that the evaluation cannot answer with any degree of confidence the questions it sets out to address. Two of us have authored an editorial to this effect (see attached Appendix 1).

There are a great number of significant failings with the method adopted for the evaluation of the BA scheme for psychology, and these bring into doubt any conclusions from the study data. The areas of concern relate to the design, participant selection, measurement and other procedures.

1.1. Selection of Participants

- The selection of participants did not follow accepted practice for ensuring sampling was adequately representative of all clients. Providers chose whether to participate, hence the sample is arguably not representative of all providers. This situation allows for considerable bias since it is quite possible that only those providers confident of positive client outcomes chose to engage. In addition, the providers subsequently chose the participants, a further jeopardy for obtaining an adequate sampling of all those having treatment. The study authors themselves state that "...the self-selection of providers and consumers may have introduced biases..." (p.6). We believe the likelihood of a significantly biased sample is higher than suggested by the authors. The participant selection procedure was simply inadequate for the task, and this situation casts significant doubt regarding the study conclusions.

1.2. Attrition

- Over 30% of clients did not complete treatment. This large attrition rate further biases subsequent outcome results obtained. Those clients are not included in the post-treatment outcome data. Current research literature recognises the importance of following up clients who drop out, since the reasons and symptom outcomes for those clients are important information in overall treatment evaluation. It is likely that clients' failure to complete is due to a limited response to intervention; hence, those with positive outcomes are likely to be over-represented in the final data. The possibility of bias toward positive outcome scores is strong. Further, we are then left with no capacity to generalise the findings to all of the clients who did commence treatment, which is a key issue in any evaluation.
- There is insufficient clinical detail for referred clients prior to treatment. For example, we have no specific information regarding the presence of known treatment complicating factors, such as personality disorder and other life stressors. One possibility is that treatment completers were less complicated in overall mental health terms, and therefore responded to treatment more readily, and with relatively higher scoring on ratings, but that cannot be determined due to lack of sufficient clinical details for referees generally. Nor is there any certainty that the initial GP diagnosis has been confirmed, and nonclinical psychologists may not be able to do so accurately, leaving open the possible bias that more of those clients selected for the study may have barely fulfilled diagnostic criteria, and were therefore easier to treat than those not selected or failing to complete.

1.3. Procedures

- The evaluation does not include a matched comparison group that received no treatment, a standard accepted practice. Thus, we cannot ascertain whether a similar group would have improved without treatment. Any study of the effectiveness of a new program or initiative

must be able to say whether it provides significant incremental benefits when compared to the absence of such spending. In other words, simply showing that participants in this program show improvements over time cannot answer this question. Indeed, any epidemiological study that tracks symptoms over time in the community will show evidence of reduction amongst those who initially score highly on symptom scales. This is due to regression to the mean effects as well as the natural history of chronic but episodic high prevalence disorders like clinical depression and some anxiety disorders. Given that the current evaluation has essentially followed a group of help seeking individuals across an initial phase of treatment, it is not at all surprising that the pre- post-test results are highly significant. But the big question is how do these changes compare to another comparison condition; a question that cannot be answered by the current evaluation. As such, the study cannot conclude that the treatment provided by the Better Access initiative is effective, let alone more effective than the treatment provided prior to the scheme. The most it can probably say is that the scheme does no harm.

- The study required providers to administer two symptom outcome scales at the start and completion of treatment, and record the scoring on a central de-identified data base. However, since the provider is aware of the clients' responses regarding the usefulness of treatment, the process is open to distortion. Clients know the provider will see their ratings, which raises the question of skewed responding in order to give a favourable (or unfavourable?) impression to providers. Thus, in addition to significant study selection bias noted earlier, there is the additional potential for response bias in relation to outcome scales' ratings. A properly designed evaluation would not rely solely on client self-report scales for best information, given the known and potentially considerable error limitations therein. It would include independent, expert assessment of clients at treatment intake, completion, and follow-up. It would also include a greater range of measures to index conditions and not be reliant on just two measures.
- The study's own follow-up procedure is markedly inadequate. There was no scales' re-rating completed, which is the accepted standard, only a brief phone interview. That interview apparently included only a broad question on subjective impressions of mental health outcomes. The matter of adequate follow-up is crucial to evaluation of psychological intervention in particular, since mental health disorder can be life-long and symptoms are known to fluctuate considerably over time. Thus, standard procedure is follow-up with the same scales over time, commonly periods of 3, 6, 12 months, or longer. Longer follow-up intervals allow data on relapse rates as well, which is critical information in evaluation of treatment, but not available from the current study.
- The study's evaluation protocol apparently does not specify a standard time interval prior to follow-up, a procedure that would not have been useful for the study in any event, since symptom ratings for individual clients were not included at the follow-up stage, only subjective impressions. No specific comparison of client status on scale scores at completion of treatment, and then at a defined period following, is possible. Further, as noted previously, there is no separate comparison group without treatment with which to compare, hence any follow-up scale data would have been of limited if any value. This

overall situation represents a major limitation on any conclusions as to whether treatment provided in the BA scheme is a success or otherwise. Follow-up scale scores are just as important, and arguably more important, than scores obtained immediately at the end of treatment.

- We conclude that, overall, the marked inadequacies of the current evaluation indicate it is fundamentally flawed, to the extent that results are of dubious value, and cannot be utilised with confidence for decision-making going forward. A properly designed and executed evaluation is required. In addition, a comprehensive evaluation will include an audit of quality of interventions provided, in order to determine the extent of best clinical practice in the BA program.

2. Qualifications and Training for Better Access

- Provision of service to clients with potentially serious and complex mental health disorders by registered psychologists with 4 years of undergraduate training and 2 years supervised psychological work only (i.e., the so-called 4+2 trained psychologists) is not in the public good. We are the educators and we know the difference between undergraduate education and postgraduate clinical education and training. The 4+2s are unqualified to deal with serious or complex mental health problems. The 4-year undergraduate psychology sequence provides basic training in scientific knowledge and scientific enquiry and is an important foundation but is totally inadequate in itself for work in mental health settings. The 2 years of supervision that follows for these psychologists is far too variable in nature and quality to ensure that they have the skills to competently deal with the mental health needs of patients. For example, many will have received supervision in environments where they are not exposed to mental health disorder. Such a low level of training is not tolerated in other professions that provide clinical services to potentially severely unwell members of the public, such as medical practice.
- Postgraduate qualifications and subsequent supervised work training in psychiatry or clinical psychology is the recognised international standard for clinical mental health work in assessing, diagnosing or treating clients. The same needs to apply for BA. The current inclusion of clinically untrained psychologists and other allied health needs scaling back. A large national scheme such as BA needs to work at providing not only best evidence-based practice, but also assure the taxpayer that the training level of providers is at least equal to recognised international first world standards.
- The BA scheme should have been commenced on a smaller scale, with inclusion of only those providers possessing the appropriate qualifications and training and who had served a specific period of time working under supervision in a government or non-government agency.
- For current providers without the requisite qualifications, we propose linking retention of Medicare privileges to attainment of a postgraduate degree in clinical psychology within a

defined period, or another suitable mechanism utilised that will reduce the scheme's reliance on unqualified providers. We believe there is no other satisfactory alternative. In the interim, current non postgraduate providers can be re-allocated to a different role that best suits their skills' level, with no requirement for specific mental health intervention skill, e.g., case management in Extended Primary Care; Aged Care. In addition, close consideration should be given to an immediate moratorium on issuing of provider numbers to unqualified persons.

- The current per capita ratio of clinical psychologists to population in Australia is still relatively small due to long-term underfunding. Numbers will gradually increase over time with more postgraduate places provided, but the latter need full funding and greater numbers than at present. Clinical Psychology is only one of many areas in health that are understaffed professionally and there is no short-term solution.

3. MBS Items

- One immediate requirement is to revise the definition of the MBS Allied Health Item "Focussed Psychological Strategies" (FPS). Currently, the Item "FPS" inappropriately includes interventions that require postgraduate training in mental health and blurs the important distinction between clinical psychologists, who are postgraduate mental health specialists, and other providers. In particular, references to functions that require postgraduate training need to be deleted, i.e., formally recognised psychotherapy functions. The terms placed incorrectly within the MBS Item FPS are: "Cognitive-Behavioural Therapy"; "Cognitive Therapy"; and, "Interpersonal Therapy" (see MBS Allied Health Services, pp. 50-51). Those functions cannot be performed effectively without extensive formal training, provided only in postgraduate courses. The basis of the distinction can be grasped from a reading of the professional competencies required for professional association membership in clinical psychology, as contrasted with non-clinical psychologists.
- As far as GP plans go we have no systematic data but from our own anecdotal experiences we have seen plans that vary from poor to an occasionally excellent one. On average they are inadequate. This is a wasteful burden on the taxpayer and is one of the big four items of expenditure under the BA scheme. The review of plans by GPs is another big BA expenditure item. We agree in the reduction of fee for this item but would prefer that this item was ceased altogether, for the following reason. When a GP refers a client to a psychiatrist there is no identified MBS item for his or her referral letter. The GP sends his or her referral letter and may give his or her diagnostic opinion. But the psychiatrist conducts his or her own evaluation, makes his or her own diagnosis, arrives at a case formulation and treats the client accordingly. This is what is expected of professional conduct and illustrates trust by the GP and health bureaucrats that the psychiatrist can assess and treat competently. The same overall procedure needs to apply for postgraduate trained clinical psychologists.

4. Access

4.1. Cost and location of services

- If one of the previous government's intentions was to engage the largest number of personnel possible for BA with the aim of extensive national coverage, that strategy has not succeeded. Many regions remain underserved, including lower SES urban areas. Alternatively, in areas of high clinical psychologist concentration that are frequently higher SES, a higher proportion of providers possess the requisite postgraduate training but frequent higher fee-setting by mental health practitioners excludes some clients due to inability to pay.
- The available Medicare data show that copayments are fairly common practice in BA generally, not only in the highest SES areas. The associated restrictions on access that follow for some clients are contrary to Medicare's intent of providing maximum equity of access, and that is a cogent point in favour of centre-based services with salaried staffing in the BA program. Others are listed below. Regarding fees, we believe these should be capped in any event at the scheduled amount, or bulk-billed, to facilitate best access. In addition, the rebate should be raised to 100% of the scheduled fee, as happens in some medical services already, to ensure affordability. A formal report on Medicare in mental health, 2009, noted a key concern of clients was higher than scheduled fees, and the negative impact on access for those less well off. It is also worth considering whether there needs to be an income cut-off for access to BA, with those above a prescribed amount not eligible for government-funded service.
- We request that the current emphasis in BA on private practice for non-psychotic disorders be revised and moved to a predominant focus on government-funded health centres, using existing facilities where possible, and with salaried staff and a comprehensive and integrated multidisciplinary approach to treatment and care. This is the most cost-effective model for federal government due to predictable and manageable funding (as distinct from private practice). Also relevant to cost containment is that the number of registered psychologists to population is likely to increase significantly in the coming years, since interest at secondary school level is high, and undergraduate tertiary courses are also very popular. We believe that a high proportion of those undergraduate only psychologists (4+2) will seek Medicare provider status and private practice, which adds further and inappropriate pressure on the mental health budget. This situation is a further strong reason to allow provider numbers only for persons with recognised postgraduate qualifications in mental health.
- Further, as clinical practitioners three of us have long-term experience in mental health multidisciplinary teams, and can attest that these provide not only better and frequent close monitoring of service quality and individual performance, but an integrated, collaborative care approach. Clinical psychologists can and should provide therapy within these teams, and can also provide useful roles in service coordination, evaluation and research as required. The centre-based approach is also particularly relevant for mental health clients,

many of whom carry other life burden issues as well as mental health disorder, e.g., family or social dysfunction, or low income.

4.2. Complex cases

- Complex cases usually require longer-term inputs than those available through Medicare-funded private practice in the BA program. Research indicates that session numbers in at least the high teens are required even with uncomplicated major depression (Hartnett et al., 2010; National Institute of Mental Health, n.d.). Hence, while the private practice model remains in place, there is a need to increase not decrease the number of sessions available per annum for clinical psychologists. It is anomalous and unacceptable that clinical psychologists, with the same level of postgraduate training in psychotherapy as psychiatrists, are reduced to a maximum of 10 sessions from 01 November 2011 whereas psychiatry is already funded by Medicare for a far higher number of sessions per annum. This situation is not only inequitable, but a clear recognition that complex cases often require far more than 10 sessions.
- Comorbid mental health diagnoses are also not uncommon in anxiety and depressive disorder, including substance abuse and personality disorders, and the matter of case severity and complexity bears directly on equity of access. The current intake procedure for BA does not specify severity or complexity of client presentation. However, a recent survey by the Australian Clinical Psychologists Association (ACPA) shows that a significant proportion of clinical psychologists' clients were indeed suffering severe, complex, or chronic conditions, with 42% having two mental health diagnoses, 30% with personality disorder features, and 33% with a chronic condition of more than five years duration. It is likely the survey results are fairly accurate. For example, in a large survey of households in the USA reported by the National Institute for Mental Health, Kessler et al. (2005a; 2005b) found that for those diagnosed with a disorder within the previous 12 months, 45% met criteria for two disorders, and chronicity was common, with 50% having age of onset by 14 years.
- The clear implication of the ACPA survey is that for a significant number of BA clients more than 10 sessions requirement is needed. The proposed 10-session limit is therefore a restrictive practice and discrimination against more complex clients in terms of access to services. Session numbers allowance for clinical psychology needs to be equivalent to that for psychiatry, and there is no sound argument against such a proposal given that clinical psychologists training specifically includes complex and severe presentations. On the other hand, since postgraduate advanced therapy and other clinical skills are required for more complex presentations, there is no valid basis for increasing the allowance with non-postgraduate trained providers, for such time as they remain in the BA program.
- The recent proposal by government to redirect those BA clients with more severe mental health disorder to the ATAPS program when clinical psychologists are trained to manage such clients is not the best use of resources. The psychology providers for ATAPS within GP

Divisions (reorganised as Medicare Locals) are frequently not postgraduate trained in mental health, hence do not possess the clinical skills required especially with complex cases. However, they are less expensive to employ, and this provides a misplaced incentive for GP groups with limited mental health funding. The logical approach is for more complex or severe cases to remain within the BA program, except for psychosis (and a small number of high-risk personality disorder cases) that are normally managed by the state mental health system.

4.3. Tied scholarships

- Another initiative for assisting with increased equity of access in underserved areas and disadvantaged groups is a trial of making available government scholarships for postgraduate clinical psychology training, and tied to a subsequent period of work in a specified area of high need. Such schemes have been employed in other professions and we support their implementation in the BA program.

5. Consequences for State Mental Health System since Medicare rebates in 2006

5.1. Poor Retention

- The majority of people with psychosis are going to continue to access most of their mental health treatment through the state public mental health systems while those with personality disorder are not included. The BA program is currently inadequate for both groups in its duration of service provision and in its lack of multi-disciplinary input. An important point is the effect that the BA program has on the retention of experienced clinical psychologists in the public system. The retention of people with this level of experience is important for two key reasons. Firstly, their clinical experience is particularly needed when dealing with the most complex clinical presentations. It is not just their knowledge of psychopathology and treatment, but their knowledge of the systems in which the patient exists, how these systems work, and how to effectively mediate multi-systemic intervention. Secondly, senior clinical psychologists perform a crucial teaching and supervision role in the public mental health system, ensuring that there will be future clinical psychologists to provide an increasingly needed service. It is the loss of this second strand, which ultimately holds the gravest threat for the people who come to the public mental health service for treatment.
- There is a strong, and rational, economic argument presented by the BA system for senior psychologists to migrate to the private system and, in so doing, essentially double their pay. For every partial engagement with the private system, the public systems' loss is likely to be proportionally greater. For example, a senior clinical psychologist previously working full time decides to do one day a week of private practice (the average clinical psychologist bills 5.5 hours per week [King et al., 2010, p.46]). The amount of income then allows this person the option of having a day not working each week, and so she chooses to work 0.6EFT in her

public role. The administration associated with a senior role is not likely to diminish; rather, it is the clinical and teaching aspects that are most likely to be sacrificed.

- Evidence for the above comes from two sources. A survey of Melbourne clinical psychologists working in the public system indicated that seniors were nearly four times more likely than their junior colleagues to reduce public hours in favour of private practice (Gleeson & Brewer, 2008). Second, the evaluation of the BA scheme (King et al., 2010) showed that growth in public clinical psychologists was stagnant, but that growth of clinical psychologists in the BA scheme was growing rapidly. It is also pertinent to this point that clinical psychologists are the largest users of the BA items both in raw terms and in hours billed per week.
- A key additional issue of course is that the number of clinical psychologists in the public mental health workforce needs to keep pace with the total growth in population not merely be maintained. If we take only the last decade, the ABS website shows the total Australian population has grown by approximately 16%. This increase needs to be matched by at least equivalent growth in state public mental health positions, and because the per capita figure for clinical psychologists 10 years ago was far too low, growth needs to have been much more than 16% since 2001.
- We believe that there are a number of key questions that were not addressed by the King et al. (2010) report and need to be pursued. These are as follows:
 1. What is the increase in the number of clinical psychologists graduating from clinical psychology programs over the past 10 years?
 2. What percentage of graduating clinical psychologists have joined the public state mental health systems over 10 years, and what percentage went straight into BA private practice each year since the inception of BA in 2006?
 3. What is the average length of tenure of clinical psychologists in the state public mental health systems since BA?
 4. What percentage of clinical psychologists, both seniors and others, are now in part-time public mental health services and/or part-time private?

5.2. Ensuring retention in the State Public Mental Health System

- It is essential to assure the community that clinical psychologists have sufficient experience in managing potential risks from clients. There needs to be work experience in the public mental health system, with acute risk management and the most severe challenging cases, before being allowed independent practice. For BA eligibility, such experience for a defined period needs to be mandatory.

- Providing an improved overall career structure for clinical psychologists in the public health system with better remuneration and availability of senior positions will assist in recruitment and retention. That improvement requires funding.

5.3. Implications for University Training Courses

- Funding for clinical psychology students at University level has been poor and became worse in 2003 with a more than halving of government funding for each postgraduate clinical Masters student. This occurred suddenly and with no explanation. Scholarships to clinical psychology students on acceptance into clinical psychology courses are needed, e.g., at the University of Melbourne, there are no scholarships for clinical students who are not undertaking the PhD as part of their studies. It is reasonable that if students did obtain a scholarship then they would be bonded to work in the public system for a period of time (2-4 years) as happens, for example, in Singapore.
- The pathway to becoming a clinical psychologist is to complete a higher degree after 4 years undergraduate training. These degrees (M Psych; D Psych) have a mandatory external clinical placement(s) component. If clinicians remain in the public system but reduce their time fraction, they are less likely to have clinical psychology students on placement as their priority. This is paradoxical since Universities were encouraged by the roll out of BA to increase the clinical psychology workforce. Further, as experienced clinical psychologists leave or reduce hours, more junior people remaining in the public system are likely to supervise clinical psychology students.
- University courses are forced to identify new training opportunities which might be in primary care or private practice but of course this means that students will not gain the expertise with the seriously mentally ill.
- Clinical psychology courses are required to run internal clinics where academic-clinicians can observe students in supervision. As at 2011 the BA program has reduced the numbers of clients attending the University of Melbourne Psychology Clinic to about 70% of pre-2006 levels. Clients able to pay the gap and whose treatment is seen to fit, or is made to fit within the number of sessions available through BA, are now accessing BA. In general, the clients now presenting to our internal clinic are less able to pay the gap in BA, require more treatment than allowed under BA, and have more complex and more severe presentations. We are also seeing more international students. In our view this also illustrates clients who are falling between the cracks. Because they do not suffer from a psychotic disorder or bipolar disorder they are not seen to fit within the purview of the existing state mental health systems nor can they pay the gap for the BA scheme or receive the length of treatment they require under BA as it stands.

6. National Mental Health Commission

There is a need to establish a National Mental Health Commission, with a brief that includes the following.

- Oversee the development of an expanded, comprehensive and integrated service format and delivery system for minors, with particular emphasis on the pre-adolescent age range. Prevention and the earliest intervention possible is the best investment for future adults'

mental well-being and better contribution to both economic productivity and the community more generally. The preferred service format for prevention and early intervention (PEI) services, where family and extended network will usually be closely involved in the case of minors, is a centre-based approach with multidisciplinary teams. For the infant or child, and carer network of adults, multiple needs for service are common, including housing, vocational or adults' own mental health problems. Transmission of mental health problems across generations is a major challenge requiring concerted effort (see Weissman et al., 2006). It needs a long term and multidisciplinary approach, including assertive outreach, and in conjunction with other government agencies.

- Develop further working linkages across different government agencies who are also stakeholders in the area of infant-child welfare, and between government agencies and NGO's. For example, close working arrangements with the Department of Families, Housing, Community Services and Indigenous Affairs is important given their role with implementing the National Framework for Protecting Australia's Children.
- Provide a quality assurance function in the evaluation of all government-funded mental health programs, and private practitioners who access Medicare. In conjunction with professional registration bodies, ensure standards of training and practice are equivalent to international first world standards, with upgrading of qualifications permitted where appropriate and required for projected workforce requirements.
- Membership of the Commission to include representation from all professional groups involved in government funded services.

7. Prevention and Early Intervention (PEI)

- It is now recognised internationally that investment in PEI for mental health as well as other health domains returns large long-term dividends for both individuals' well-being (and savings on services not required), and for broader economic productivity. For example, "The UN's ILO now estimates that mental illness accounts for up to 4% of GDP, which equated to \$40bn in the Australian economy" (Independent Mental Health Reform Group, March 2011, p.6).
- Many mental health disorders, including high prevalence Axis I as well as Axis II, are due largely to negative early family and other relationships experience, and are therefore either preventable or can have risk reduced substantially by early intervention. The proposal in the May Budget to provide a basic check for three year olds' social-emotional health is markedly insufficient. Allocation of a higher proportion of mental health funding generally to PEI is important, including a substantial part of the BA budget. In contemporary practice, any large scale program such as BA should also give recognisance to the importance of PEI, including from the prenatal period. For example, although the primary focus is on treating adults' symptoms, clients can present with numerous life stressors, and for those with a young family a focus on prevention of intergenerational transmission of symptoms is vital. It

is reported that approximately 14% of children aged 4-14 years have significant mental health problems (Department of Families, Housing, Community Services & Indigenous Affairs, 2011, p.xvii). Other needs for service may include more appropriate housing or vocational pursuit, lack of which can add to stress that drives the maintenance of symptoms. Of concern, with the structure of BA in Medicare focusing on service for individuals, there is no ready mechanism for seeing family members.

- At the broader policy level, and in recognition of the importance of PEI, two years ago the federal government introduced a National Framework for Protecting Australia's Children (Department of Families, Housing, Community Services & Indigenous Affairs, 2009). One key aim is better integration, access and improved service quality for clients, adult carers, and their community-based practitioner teams. It is also clear that the economic cost to the community of child abuse is very large (Bromfield, Holzer, & Lamont, 2011), as is the cost to individual well-being (see Attachment 2). We must do better for the younger age group.
- As in child protection services, PEI in mental health is best delivered within a multidisciplinary centre-based service format. That can provide for collaboration on a range of client service needs as well as other preventative functions, such as community education, and parenting education and support. This situation adds to the proposal for reducing significantly the emphasis on private practice in the BA program.
- PEI needs to be a centrepiece in developing the National Mental Health Policy. In that pursuit, we recommend the recent Position Paper: "Improving the Mental Health of Infants, Children and Adolescents in Australia" (Australian Infant, Child, Adolescent & Family Mental Health Association: www.aicafmha.net.au/resources/index.html), which provides a useful framework to consider.
- The bigger overall picture that will assist PEI as well as other functions in health generally is an overarching set of national standards and integrated programs, of which mental health forms part.

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1 August 2011

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