ACP
ASSOCIATION OF
Counselling
Psychologists

Senate Community Affairs Committee: Commonwealth Funding and Administration of Mental Health Services.

4 August 2011

Association Of Counselling Psychologists

CONTACT INFORMATION

Ben Mullings (ACP Chair)

Email ben@psyber.net.au
Telephone 0431 870 401
Facsimile (08) 9317 6166

4 August 2011

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

Dear Mr Holland,

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

The Association of Counselling Psychology is pleased to respond to the current senate inquiry regarding the proposed changes to the *Better Access to Mental Health Care* initiative and related policy changes outlined in the Commonwealth budget earlier this year.

Our submission refers to the following items in the Terms of Reference:

(a) the Government's 2011-12 Budget changes relating to mental health;
(b) changes to the Better Access Initiative, including:
  (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;
(c) the impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program;
(e) mental health workforce issues, including:
  (i) the two-tiered Medicare rebate system for psychologists,
  (ii) workforce qualifications and training of psychologists, and
  (iii) workforce shortages;
(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.

Further to our submission the ACP requests an opportunity to appear before the Senate Committee should further clarification be required regarding the specialist role of Counselling Psychologists in mental health care.

We thank you for this opportunity.

Ben Mullings (Chair)
Association of Counselling Psychology

Key Recommendations

1. The *Better Access to Mental Health Care* initiative targets high-prevalence mental health disorders in the general community, spanning mild, moderate and severe levels - this should not be arbitrarily changed. Fragmenting service provision across the *Better Access* and *ATAPS* scheme will make the system more complicated and will needlessly increase stigma for distressed people in our general community.

2. The pathways to accessing psychological services need to be expanded further, rather than restricted. Avenues for direct access to a Medicare psychologist should be considered as well as retaining the existing GP referral pathway.

3. The 12-session system with 6 additional services for those who need them, must be retained or expanded further, rather than reduced to 10 sessions with no exceptions. There are several important reasons for this.
    a. Reducing treatment below minimal guidelines is more costly for the public.
    b. Offering only 10 sessions of treatment will reduce help-seeking behaviour.
    c. Forcing the public to utilise *ATAPS* or see a psychiatrist, rather than accessing further psychological treatment with a trusted psychologist is stigmatising.
    d. Reducing treatment to 10 sessions contradicts scientific evidence.

4. The *Better Access* initiative should not be traded off against the *ATAPS* program. These are complementary programs and the public requires both systems to adequately address mental health issues in the general community. The shift in funding gives sub-standard care to people who suffer from the most widespread mental health disorders.

5. The current two-tiered system is flawed on multiple levels and must be replaced. The ACP suggests two options:
    a. Collapse the two-tiered system and offer a single Medicare rebate for all members of the public who require psychological services.
    b. Restructure the two-tiered system to include a broader range of skilled practitioners in mental health care. This must be linked to an independent assessment process, rather than linking Medicare status to a private membership body.

6. Changes to the *Better Access* scheme and other mental health programs must be more carefully considered in the future. Negative impacts have been felt by the psychology profession, but in the long-term, this may have flow-on effects, impacting the general community with workforce shortages and lack of support for services.

7. Internet-supported psychological services need further investment, particularly in the area of systems utilising interaction in real-time with psychologists, such as videoconferencing and Internet chat communication. Self-guided web-based services are useful, but should not be considered a substitute for face-to-face services.

8. We ask the senators to be aware of false claims to superiority that are being made by an organised lobby group in the current senate inquiry. We urge the senate inquiry to carefully weigh up the submissions on the basis of confirmable evidence.

9. The ACP strongly urges the Government to consider ways to develop fair and inclusive policies that accurately identify the full range of skilled practitioners with expertise to contribute to mental health care.

10. We request that policy-makers change the Medicare system to give inclusive recognition to Counselling Psychologists and other specialists in mental health care. The current system discriminates against those who turn to a Counselling Psychologist when they are reaching out for help.

11. Policy-makers should avoid making overgeneralisations about the relative disadvantage of mental health consumers on the basis of their suburb where they live. Mental health consumer feedback and large-scale practitioner surveys show that the majority of people utilising services in the Better Access system would otherwise be unable to afford services without the high rates of bulk billing and low gap fees that are presently available in the scheme.

12. The ACP questions the independence of the Mental Health Expert Working Group, on the basis that a significant number of the members of that group have a long-standing bias against *Better Access* and a conflict of interest towards funding their own projects.

13. The Government needs to deliver on their stated commitment to mental health services in the general community as a matter of public trust. The ACP welcomes increased funding of a broad range of mental health services, but it is unacceptable to dismantle our existing mental health services across Australia.

Terms of Reference

A selection of items from the terms of reference relevant to the ACP are addressed below:

(a) the Government's 2011-12 Budget changes relating to mental health; and
(b)(ii) the rationalisation of allied health treatment sessions

Since its inception, the *Better Access* initiative has targeted the full spectrum of mental health disorders, including people experiencing complex, chronic and severe psychopathology. By contrast, the *Access to Allied Psychological Services* (ATAPS) program has always been specifically targeted to 'mild to moderate' mental health disorders. The current operational guidelines manual for the ATAPS program (2011) reinforce that point (page 3):

> *"ATAPS in its current form is particularly suitable for providing short term psychological services to individuals with mild to moderate common mental illness".*

The Government has attempted to arbitrarily redefine the client population who utilise both of these schemes in their new budget proposals. The population served by the *Better Access* initiative are in over 80% of cases those with moderate to severe levels of psychopathology (DoHA, 2011; Giese et al., 2008), not those with 'mild to moderate' levels of distress.

The advantage of the current structure of the *Better Access* system is that it allows vulnerable and distressed people with a mental health disorder to begin receiving psychological services in a timely manner when they reach out for help. Redefining the treatment boundaries in the way that has been proposed in the new Commonwealth budget, will make it far more difficult for such people to navigate their way through the system. Under the proposed arrangements, if a person's condition deteriorates after they use the 10 sessions allowable under the *Better Access* initiative, they will be forced to prove they have a severe condition and potentially required to access a different therapist. This is not a sensitive way to handle people who are experiencing complex problems and severe levels of distress, which in some cases, is associated with ideation about suicide and self-harm. We also point out that it is extremely stigmatising from the vantage point of consumers to be made to prove how serious their condition is and to be put into case managed programs rather than simply continuing to see a psychologist as required. Fragmenting mental health care services in the way that is being planned is likely to produce premature terminations and negative treatment outcomes.

From a practitioner perspective, the ACP advises the senate inquiry that the target population serviced by the *Better Access* initiative should be left as it is: namely, high prevalence mental health disorders in the general community, inclusive of mild, moderate and severe levels of psychopathology. Splitting mental health services in terms of symptom severity across *Better Access* and *ATAPS* goes against the evidence about how these services are actually utilised by the general community. The proposed separation of *ATAPS* and the *Better Access* scheme in terms of symptom severity will needlessly complicate the system, and is likely to increase stigma associated with seeking mental health care.

(b)(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

The ACP is concerned that the new rebate structure for GPs will discourage doctors from referring to the *Better Access* scheme. Recent articles and direct correspondence with medical groups indicate

that up to 20% of GPs are stating that they will no longer provide *Mental Health Care Plans* if the proposed changes go ahead. This will stop patients from being able to access psychological services. Given that this is the only pathway at present for distressed members of the public to access this scheme, we question whether it is truly in the public interest to create a policy that provides fewer ways for people to access psychological care when they need it. On this point, the ACP remains of the view that people seeking psychological help should be able to see a psychologist first, rather than having to make an appointment with a GP. This additional pathway will allow people who require mental health care to begin treatment in a timely and uncomplicated manner. That is, people with a mental health disorder should be able to begin the treatment process either with a GP or a psychologist. Both pathways to accessing psychological services should be available to members of the public.

We propose that psychologists are the best equipped practitioners to conduct a thorough psychological assessment at the beginning of treatment. In our view, an initial period of 3 sessions should be available to all Australian citizens to develop an accurate diagnosis and to provide an initial report to a client's preferred GP. At this point, the GP would conduct their medical assessment with the patient, so that any medications that are required can be administered. This change in policy will promote shared-care by providing a psychological case formulation and treatment plan to add information and work alongside any medical treatment decisions made by the patient's GP.

The ACP also proposes that the follow-up report should occur after an extended period of uninterrupted treatment, rather than at the 6 session mark as is currently the case. This will increase the likelihood that a person will experience a significant reduction in their symptom severity. At the very least, the ACP would advise that patients should be eligible for 12 sessions of treatment at the very least, in addition to the 3 sessions of assessment mentioned above. The ACP points out that the policy decision to approve 12 sessions of cognitive-behaviour therapy (CBT) or interpersonal therapy (IPT) under Medicare was based on preliminary findings from the Treatment of Depression Collaborative Research Program conducted by the US National Institute of Mental Health – the largest controlled study of depression world-wide. Follow up studies by the chief researcher found that 33% of the sample relapsed within 18 months. The researchers stated: "The major finding of this study is that 16 weeks of these specific forms of treatment is insufficient for most patients to achieve full recovery and lasting remission" (Shea et al., 1992). These results are confirmed in a recent study by Harnett et al. (2010) demonstrating that for reliable improvement to be shown in 85% of cases, at least 20 consultations with a psychologist are required. They specifically note that under the current Medicare system in Australia where only 12 consultations are available with a psychologist, only a third of people are likely to show a lasting improvement to their condition. To factor this evidence into the current policy, the additional 6 sessions for 'exceptional circumstances' should be maintained, but given another label to avoid stigma. A chart summarising our recommended additional pathway is provided in Appendix 1.

The ACP is of the view that access to psychological services should be uncomplicated and timely for members of the public who have a mental health disorder. The propose cuts to GP referral pathways threaten to restrict access to the *Better Access* scheme. Likewise, the lack of a direct pathway to see a psychologist undermines the overarching purpose of the scheme. If the scheme is meant to help members of the general community to access psychological services when they have a mental health disorder, then these pathways to accessing these services must be expanded instead of restricted.

(b)(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

Reducing the amount of psychological treatment that is allowable under the *Better Access* scheme is a dangerous policy that will not only prevent those who are most in need from receiving evidence-based care, but will also undermine the entire basis for this highly successful initiative. Recently the ACP prepared a letter to the Federal Minister for Mental Health, the Hon Mark Butler, on the behalf of a large consumer group numbering thousands of people. Since the Commonwealth budget was unveiled, this group of consumers organised an online petition with over 4000 signatures and formed a Facebook Group, where they have brought together some of their concerns about the changes to mental health care that are being planned by the Government. These concerns were drafted into the 13-page document we have attached as Appendix 2. Rather than go over these points again, we refer you to the attached document.

In summary the impact of the cuts to psychological services are as follows:

(1) Reducing treatment below minimal guidelines will cost Australian tax-payers more over time.
(2) Offering only 10 sessions of treatment will reduce help-seeking behaviour.
(3) The proposed reforms stigmatise mental health care, particularly for depression and anxiety.
(4) Reducing treatment to 10 sessions, without any exceptions, contradicts scientific evidence about the amount of psychological therapy required for even the most uncomplicated mental health disorders.

(c) the impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program;

The ACP has concerns about the proposal to shift both funds and psychological services away from the fee-for-service model that is utilised in the *Better Access* initiative, redirecting them towards a 'care package' approach, where multiple mental health professionals are involved in managing a single case. Whilst this approach is suitable in niche areas of special need, it is certainly not warranted for the overwhelming majority of people who have depression and anxiety, which are the most prevalent mental health conditions in our society. We anticipate that this shift in emphasis is likely to result in our already over-stretched mental health workforce being committed to provide services around a limited number of cases, at the expense of a significant number of other people in the general community who could otherwise be helped. To our viewpoint, new investment in these programs should not come at the cost of existing mental health services in the *Better Access* system.

We are also aware of several recent reviews of the *ATAPS* program that underline our concerns about the proposed changes (Department of Health and Ageing, 2010; Australian National Audit Office, 2011). The recent audit by ANAO (2011) repeatedly states that there have been considerable problems monitoring and controlling administrative costs under *ATAPS*, and maintaining compliance with the program across GP divisions. The audit points to inequalities associated with the allocation of funds on the basis of need. The arguments that we have heard from those attempting to justify cuts to the *Better Access* program, have been that funds would be more equitably allocated via the *ATAPS* program, yet these findings from the Auditor General's report do not bear out that claim.

Further to this issue, both the ANAO audit and the DoHA review of the *ATAPS* program (2010) point to significant cost blowouts associated with administration fees. The ANAO audit noted that there is a routine expense of 15% of all funding allocated to *ATAPS* being spent on administration, with

peaks that are frequently at the 25% mark. To put a human face to this figure, this means that for every 4 people that receive psychological services under ATAPS, one person is missing out.

The impact of cost blowouts in the *ATAPS* program reported in the DoHA review also show that during the 2008/09 period, the cost of delivery of services in *ATAPS* ranged from $57 to as high as $631 per session. Part of this cost is associated with the fact that *ATAPS* provides a salaried funding arrangement, meaning that tax-payers are funding sessions where the client does not attend, or where very few people in the community participate in the programs that are being offered. This is in stark contrast to the fee-for-service arrangement in *Better Access*, where the taxpayer only funds the delivery of legitimate psychological services. The ACP takes the obvious position that this represents far better value for money to the Australian taxpayer.

One of the major concerns raiseds by the new proposal is that the *ATAPS* scheme will be managed through the new *Medicare Locals* system. We have been advised that under the *Medicare Locals* system, GPs will not be able to refer patients to the *ATAPS* programs in their region when that patient lives outside of their catchment area. On face value this might not seem like much of a problem, however, we ask you to consider the fact that many people have a trusted family GP that they visit across their adult life. This is encouraged by medical practitioners and there are some good reasons for this, such as the GP knowing the history of that patient and developing trust. When a person moves house however, in many cases this will take them some distance from their family GP. Many people continue to drive some distance to see their trusted family doctor. If a GP is unable to refer them to the *ATAPS* scheme, it would seem the new system is creating needless barriers that will obstruct people with mental health disorders receiving timely and appropriate care.

The *ATAPS* program is a more labour-intensive and expensive option for the delivery of psychological services. There are significant barriers associated with relying on the *ATAPS* scheme that will obstruct many people from accessing appropriate psychological services to meet their needs. The ACP is of the view that the *Better Access* initiative and the *ATAPS* programs are complementary systems that should not be competing for funds. By our calculations, the Better Access initiative provides better value for money in the provision of flexible psychological services that are appropriate for the majority of consumers. Given the over-stretched and under-resourced mental health workforce that we currently have in Australia, the ACP would like to see public funds being allocated to the most cost-effective forms of service delivery. If the Government is genuine about treating mental and physical health equally in the system, then reducing psychological services below minimum treatment guidelines in order to fund the *ATAPS* scheme does not live up to that commitment to the Australian public.

(e) mental health workforce issues, including:
(i) the two-tiered Medicare rebate system for psychologists

The two-tiered system in the *Better Access* scheme is problematic on a number of levels, as follows:

The two-tiered system fails to accurately identify mental health specialists

In the current structure of the health system, both locally and federally, a false dichotomy has been set in place by Medicare policy makers, classifying psychologists as belonging to one of two categories: (1) clinical psychologists and (2) generalists. This classification system fragments the profession of psychology into two groups, when in fact there are a number of specialist groups in the field of psychology with expertise in mental health care. Consequently, specialists in the areas of Counselling Psychology, Neuropsychology, and Forensic Psychology and Developmental Psychology

are incorrectly classified by the system as having only basic skills (i.e., as 'generalists'), when in fact, these specialists have well-established advanced training in assessment, diagnosis and treatment of chronic, severe and co-morbid mental health disorders. This policy in the current health system has caused significant controversies since 2006, due to the fact that specialists from other areas have been forced to demonstrate eligibility to join the APS College of Clinical Psychology.

This requirement has made it a requirement for psychologists to become incorrectly classified as Clinical Psychologists in order to have their expertise in mental health care noted, rather than being accurately identified in the first place for their existing skills (Carey et al., 2010). Up until last year there was no other way for other specialists to be recognised for the advanced skills that they already possess in mental health care, but since then, even that pathway has been shut down. As a result, the current system now does not recognise any other mental health specialists, regardless of their training, supervision and experience with the most severe cases. This requirement violates the democratic principle of *Freedom of Association* which is enshrined in many important areas of our legislation in Australia including the *Industrial Relations Act*. The ACP would like to see the requirement for skilled practitioners to associate with the Australian Psychological Society removed and replaced with a system that is fair and impartial to all specialists in mental health care.

The divisive and baseless classification system for psychologists that currently exists in Australian health policy negatively impacts on some of the most vulnerable and disadvantaged people in our society. As it stands, those who seek psychotherapy from a Counselling Psychologist are currently forced to pay larger gap fees than their counterparts who consult with a Clinical Psychologist. Despite extensive training and experience in mental health care, the current policy fails to identify the contribution of Counselling Psychologists. This discourages many Counselling Psychologists from contributing as Medicare providers. The overall effect of the current policy is that fewer specialist psychologists are accessible to the public out of the lack of recognition given to the breadth of our existing mental health workforce.

The two-tiered system fails to differentiate client groups

Although Clinical Psychologists have claimed that they see a larger proportion of clients with complex and severe mental health disorders, all of the evidence shows otherwise. The recent evaluation of the *Better Access* scheme demonstrated that both categories of psychological service providers saw people with the same severity and complexity of presenting mental health disorders (DoHA, 2011). These findings align with earlier surveys, showing that both tiers of Medicare psychologists saw clients with the same types of conditions (Giese et al., 2008). To date, research has repeated shown that over 80% of people utilising the *Better Access* scheme have moderate to severe symptom severity. To put it simply, there is absolutely no evidence to support the claim that psychologists with top-tier Medicare status are seeing more complex or severe client cases. People who have a mental health disorder typically seek out the most appropriate psychologist to match their treatment needs, rather than basing their selection on whether a psychologist is classified by Medicare as a 'clinical psychologist' or a 'generalist'.

The two-tiered system fails to produce superior outcomes

Similar to the above point, the recent *Better Access* evaluation conducted by DoHA (2011) has demonstrated that both tiers of psychological service provider are equally effective in treatment. In measurable terms, both groups of practitioner performed equally well in the same work with the same client population. Again, this matches with earlier surveys showing that an equivalent proportion of people improve over the course of psychological treatment across both tiers of psychology service providers in the *Better Access* scheme (Giese et al., 2008). The current way of

classifying practitioners in *Better Access* amounts to a spurious dichotomy, cleaving the profession into two groups that do not differ on relevant treatment factors.

The two-tiered system fails to categorise psychological services appropriately

The *Better Access* initiative currently makes a distinction between 'focussed psychological strategies' (FPS) and 'psychological therapy' that, outside Medicare legislation, has no meaning or any relevance to contemporary psychological practice. There is no theoretical basis or research evidence in the area of psychology to suggest that any such a distinction can or should be made. It is arbitrary, inaccurate and highly discriminatory, yet this system is used by Medicare to distinguish between Clinical Psychologists and other psychological specialists such as Counselling Psychologists. As such, this system discriminates against people who access a Counselling Psychologist, regardless of their expertise in mental health care. The description of Counselling Psychology maintained by the APS College of Counselling Psychology and the Psychology Board of Australia, bear out this point:

> *"Counselling psychologists are specialists in the provision of psychological therapy. They provide psychological assessment and psychotherapy for individuals, couples, families and groups, and treat a wide range of psychological problems and mental health disorders."*

Given the description above, it should be clear that it is misleading and degrading to practitioners for the *Better Access* system to incorrectly categorise Counselling Psychologists as merely providers of 'focussed psychological strategies' rather than 'psychological therapy'. Counselling Psychologists are clearly highly advanced psychological therapy practitioners in the profession. Therefore if the Government insists on having two-tiers of practitioner in *Better Access,* it stands to reason that Counselling Psychologists must be given equivalent recognition as psychological therapy providers.

The current two-tiered system is full of problems. This aspect of the system fails on almost every level, creating false dichotomies about the psychological interventions used in the scheme, the skills of mental health practitioners who apply these interventions, the severity and complexity of client problems amongst those who utilise services, and most importantly, it fails to deliver superior therapeutic outcomes. The ACP suggests that there are only two possible solutions. First, the Government may opt to collapse the two-tiered system and offer an equitable rebate for all people who access psychological services. The second option would be to broaden the scope of inclusion to the top-tier, so that it is inclusive of other mental health specialists. If this latter approach were taken, it would be sensible to determine eligibility for the top-tier through an impartial body, such as the Psychology Board of Australia, rather than the APS. The democratic principle of *Freedom of Association,* which is embodied in many important pieces of legislation such as the *Industrial Relations Act,* must be respected. For this approach to succeed, a standard benchmark for demonstrating advanced mental health skills would need to apply for all applicants, rather than giving preferential treatment through automatic eligibility for Clinical Psychologists or members of the APS College of Clinical Psychology. Adopting this stance may encourage practitioners to undergo advanced training in mental health care, without discriminating against specialist groups.

(e)(ii) workforce qualifications and training of psychologists

Further to the points made in the above section, the current two-tiered system has had a severe impact on the diversity of the profession of psychology in Australia since it was introduced. It has been noted by many critics that post-graduate courses have actually closed in many places across Australia, due to the fact that students have felt pressured to undertake Clinical Psychology training rather than their preferred area of interest. This has massive implications for the psychology

profession, most notably the outcome that diversity is being squashed in favour of homogenising post-graduate training and research around Clinical Psychology. This negative impact on the psychology profession may not have been the intent of policy-makers when they created the system, but the reality is that research and training opportunities are no longer as diverse. The long term impact of this on Australia, as it sits in the international context, must be considered properly.

(e)(iii) workforce shortages

The May 2011 figures collected by the Psychology Board of Australia indicate that there are 4375 clinical psychologists in total, many of whom work in the public system, rather than in the private sector where they can be drawn upon for the *Better Access* scheme. Counselling Psychology is the second largest domain of specialisation, with 747 practitioners, amongst whom approximately half provide services in private practice. The ACP is of the opinion that even these numbers put together are grossly insufficient to tackle Australia's need for high quality evidence-based mental health care. We urge the Government to consider broadening the scope of expertise that is recognised and to acknowledge the existing competencies of our mental health workforce.

Policy-makers need to carefully consider how changes to the Better Access system will impact on our mental health workforce. If policy trends continue to marginalise skilled practitioners from engaging with the mental health workforce, it will be most felt by ordinary people in Australian society. Practitioners have already reported to us that they are considering early retirement or leaving Australia to pursue a more rewarding career in other parts of the world. These are the real effects of policy decisions that do not appropriately acknowledge the skills of our existing workforce.

(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

The ACP would like to make the point that online services should not be seen as a replacement for face-to-face therapy, but rather, another tool to deliver services to hard to reach groups. A chief complaint from local people living in rural and remote areas is that policy-makers may end up relying on cheap, automated alternatives to therapy, rather than doing more to attract skilled practitioners to distant regions of Australia. Policy-makers must be careful not to create a scheme where automated services become the substitute for face-to-face psychological services in regional and remote Australia. Rather, we must recognise that for some people, face-to-face services will be required, whereas for others, they may benefit from self-guided web-based services, video-conferencing, or online 'chat' with a psychologist.

We point out that Counselling Psychologists have specific expertise to bring to research about the use of psychological interventions over alternative modalities, such as Internet communication (Mallen & Vogel, 2005). One of the key findings from research of this kind is that meta-analytic studies show larger treatment effects associated with human-supported web-based interventions by comparison to those that are purely self-guided (Barak et al., 2008; Spek et al., 2007). Historically the Australian Government has directed funding to psychological services that are for the most part self-guided, rather than those that involve real-time interaction with a psychologist (e.g., MoodGYM, CRUfAD, eCouch, and Anxiety Online). Whilst these services certainly can be helpful to some people, the evidence shows that better therapeutic outcomes are associated with greater levels of therapist involvement in the interaction. Therefore, we suggest that policy-makers focus more resources on services that incorporate Internet chat communication and video-conferencing, particularly as Internet speeds increase with the growth of the national broadband network.

The ACP supports the use Internet technology to expand the reach of psychological services to regional and remote Australia, provided that these services are not considered a substitute for face-to-face services and that more resources are allocated to treatment models where there is real-time interaction with a psychologist. Treatment models where Internet chat and videoconferencing form a large component of service delivery need much greater investment into the future.

(j) any other related matter

We have a number of other points to raise about the planned changes, as follows:

False Claims to Superiority

The ACP is very concerned by a campaign encouraging members of the APS College of Clinical Psychology to lobby en masse in the current Senate Inquiry with exaggerated claims about the superiority of Clinical Psychologists in mental health care. Our information, from a leaked email forwarded to us from multiple sources, is that this lobbying campaign was launched through the bulk email system by the national chair of the APS College of Clinical Psychology. At the time of preparing this document we have identified that there are at least 67 submissions (59% of the current total of 113 submissions) that make direct quotations from the email that prompted this smear campaign. We will deal with three elements of this lobbying campaign that sum up our concern.

First, we bring your attention to a quotation from the opening sentences of the email:

> *"The Senate Community Affairs Committee has concluded that there are no grounds for the two-tiered Medicare rebate system for psychologists and recommends the single lower rate for all psychologists including clinical psychologists....."*

The above sentence is quoted verbatim in some submissions and appears to be the basis for a large amount of the others. This completely fabricated quotation is worded in such a way that suggests that a decision has already been reached to collapse the two-tiered system of psychological services to a single-tier. It is critical for senators to understand that the reactionary responses received in the current senate inquiry are a defensive move on the part of most of these writers, reflecting in-group bias. There is in fact no data from any research, either in Australia or abroad, that substantiates the superiority of Clinical Psychologists over any other group of skilled practitioners who deliver mental health services in the general community. Most of the claims relate to precedent alone in the hospital system. We therefore request that groundless claims to superiority be dismissed. These exclusive claims to unique expertise are not in the interests of those seeking high quality mental health services across Australian society.

Second, one of the most frequently used statements appearing in the submissions before the current senate inquiry is the claim that Clinical Psychologists are the only group whose entire training is based on mental health care:

> *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 psychopathology, assessment, diagnosis, case formulation, psychotherapy, evaluation and research across the full range of severity and complexity.*

This misleading statement implies that: (a) Clinical Psychology training exclusively focuses on these areas; and (b) no other specialist training covers the full range of symptom severity and complexity. In fact, most Clinical Psychology courses contain elements of training outside of those listed areas that relate to other work, such as parent-child attachment, family conflict, and other contextual factors, which overlap considerably with the training of Counselling Psychologists and other specialists. In addition, the other specialist domains of psychology do in fact deal with the full range of severity and complexity of cases that present in the population they see. For specialist Counselling Psychologists, the focus is on the general community setting, which the *Better Access* initiative is designed for. In any case, where a presenting client has a problem that goes beyond the expertise of a specific practitioner, that psychologist has an ethical responsibility to refer them on. This applies just as much to Clinical Psychologists as it does to any other mental health practitioner.

Third, we point out the use of grossly misleading statements used in the lobbying campaign. As a case in point, under section 1.1.2 of the bulk email calling on members of the APS College of Clinical Psychology to lobby en masse, reference is made to a report from the Joint Review Group of the British National Health Service (NHS) to various levels of skill in mental health care:

> *"it is the skills required for level 3 activities, entailing flexible and generic knowledge and application of psychology, which distinguishes clinical psychologists..."*

What the author has failed to mention however, is that earlier in the report the Joint Review Group states that the review would only focus on Clinical Psychologists, without reference to any other specialist domains of psychology. Immediately after the aforementioned quote, they repeat this statement:

> *"Since the vast majority of psychologists currently employed in the health services are clinical psychologists the Joint Review Group has not considered the position in relation to the roles of other relevant psychological specialisms in detail."*

In other words, the Joint Review Group was comparing mental health professions (that is, comparing clinical psychologists to social workers, and paraprofessional psychotherapists, and so on), rather than comparing one specialist area of the Psychology discipline to another. The other problem with the quote that was cited is that it is over 20 years old! The current place of Counselling Psychologists in the NHS is summed up on the 'NHS Careers' website (2011):

> *"Counselling psychologists apply psychology to working collaboratively with people across a diverse range of human problems. These include helping people manage difficult life events such as bereavement, past and present relationships and working with mental health issues and disorders... Counselling psychologists work within the NHS both in general and psychiatric hospitals and GP surgeries."*

As you can see, Counselling Psychologists are well-regarded in the NHS as providers of high quality mental health services, as they are in North America and the rest of the developed world. Claims to superiority in mental health care that you have been reading in some of the other submission are simply unfounded self-serving bias for those practitioners making these claims.

The ACP would like the senate inquiry to be mindful of the fact that many of the submissions that have been received so far are a direct result of a smear campaign to drown out other perspectives in the profession of psychology. We point out that most of these claims lack any substantive basis and that many of the claims being made are inherently self-serving. We urge the senate inquiry to weigh up these submissions on the merit of firm evidence, rather than speculation or self-appraisal.

Equivalence of Training in Mental Health Care

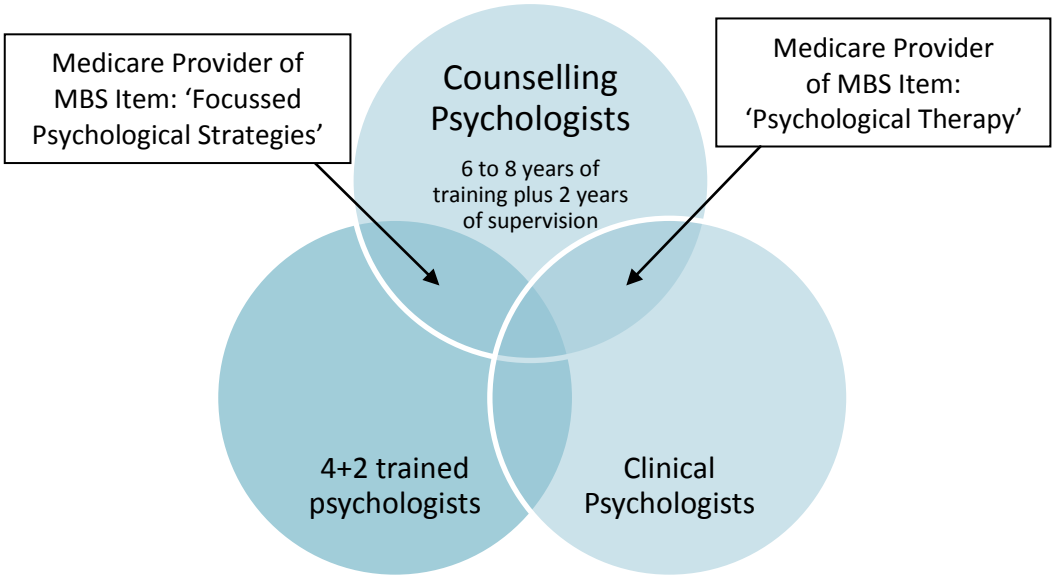
The most repeated claim appearing in submissions to the senate inquiry so far are that there is a "vast difference" in the training of Clinical Psychologists compared to every other type of psychologist in the Medicare system. This is not actually the case, despite how many people have made this claim. A large proportion of psychologists who work in private practice, but are classified as 'generalist' Medicare providers, actually have 6-10 years of post-graduate training relevant to mental health. During the negotiations about specialist registration in the field of psychology at the beginning of 2010, a large web-based survey was conducted within the profession, indicating that over 65% of psychologists who were classified as 'generalists' by Medicare possess post-graduate training at the Masters level or above (N=125).

We point out that the first 4 years of psychology education are common to all psychologists. However, with regards to specialist post-graduate training after those 4 initial years, the APS and APAC report that the overlap in material covered by the different specialist areas is as high as 80% of the content. This amounts to less than a semester of education in difference. Even factoring in placements for Clinical Psychology courses, the bulk of these are shared by both Clinical and Counselling Psychology trainees, so they see the same client population for the most part of their training. It simply does not follow that the training of Clinical Psychologists is as vastly different as is being claimed by some people responding to this senate inquiry. On the contrary, it is obvious from post-graduate course outlines that there are few differences in the training at all. Hence, we put it to the senate inquiry that the claimed differences are being grossly exaggerated.

Some who have lodged submissions have claimed that only the most advanced students enter Clinical Psychology courses or that they have higher standards of professional development. This is also factually inaccurate. All specialist domains of psychology related to mental health (Counselling Psychology, Neuropsychology, Developmental Psychology, and Forensic Psychology) have the same high standards of professional development requirements. And in each case, they all require their students to be of the highest calibre, assessing the academic performance, personal abilities and the professional background experiences of applicants at the point of entry before admission. No single group of applied mental health specialists in the field of Psychology are superior to the others.

Despite having extensive training as specialist providers of psychological therapy for people living in the general community, a large proportion of Counselling Psychologists are incorrectly classified as 'generalist' providers. We call on policy makers to resolve this problem by providing appropriate recognition of our specialist group as being equivalent mental health care providers in the general community.

The Venn diagram shows the current problem with how Counselling Psychologists are categorised in the Medicare system. To be clear, the current flawed policy incorrectly classifies Counselling Psychologists as providers of FPS services by default rather than correctly identifying them as providers of 'psychological therapy' – the specialist domain of Counselling Psychology.



The ACP contends that the exclusive claims to superiority in mental health care that have been submitted to the senate inquiry amount to elitism at best, or at the worst, a campaign of professional discrimination. We ask that our decision makers in Government appreciate that these claims come from an organised factional minority that are not representative of our profession.

Psychology is a diverse profession and there are a variety of skilled practitioners in our field that possess advanced training, supervision and expertise in mental health care. The ACP strongly urges the Government to consider ways to develop fair and inclusive policies that accurately identify the full range of skilled practitioners with expertise to contribute to mental health care.

Counselling Psychologists as Mental Health Care Providers

Counselling Psychologists are the second largest specialist group in psychology with advanced-level training in mental health care. The attached 'Domains of Knowledge' document for the APS College of Counselling Psychology (Appendix 3) demonstrates that Counselling Psychologists are second to none in their high standards of training in mental health care for people living and interacting in the Australian community. By comparison to other groups, the training of Counselling Psychologists is focused on the broadest range of evidence-based psychological therapies and emphasises treatment in the general community. Over half of Counselling Psychologists provide services in private practice. The focus of training Counselling Psychologists aligns with the priorities of the National Health and Hospitals Reform Commission, in terms of prevention, early intervention, community-based treatment, and helping people attain better health and independent living.

The archival description of Counselling Psychology and the 'Model Training Program' description for Counselling Psychology in the US make it abundantly clear that as an entry level standard, Counselling Psychologists must possess specialized skills in the assessment, diagnosis and treatment of mental health disorders (American Psychological Association, 1999; Murdoch et al., 1998). This is also reflected in the specialty definition for Counselling Psychology maintained by the Council of Specialties in Professional Psychology in the US (2010). There is a substantial area of overlap

between Clinical and Counselling Psychology. Studies conducted in the USA make a direct comparison between these specialist areas of psychology, concluding that a merger should take place. Johnson and Brems compared Clinical and Counselling Psychology in the US across a number of areas, including training content (1991), publication productivity (Brems, Johnson, & Gallucci, 1996), job-related activity (Brems & Johnson, 1996) and theoretical orientation (Brems & Johnson, 1997). This research, like many other studies, reveals that there are few practical differences between Clinical and Counselling Psychologists. These conclusions align directly with the findings of the Association of State and Provincial Psychology Boards in the US, which have overseen standards in specialist psychology since 1961. In a series of wide-scale research projects surveying the practices employed by various types of psychologists, the ASPPB have shown repeatedly that there are no differences between Clinical and Counselling Psychologists in terms of the settings they work, the clients they see or the psychological practices they employ (Greenberg et al., 1996; Greenberg & Jesuitus, 2003).

The Australian focus of Counselling Psychology mirrors North America (Grant et al., 2008). A recent study conducted by Orrum (2005) reveals that in Counselling Psychologists in Australia work frequently with people who have mood disorders (84%), anxiety disorders (91%), and with sexual abuse (including both PTSD symptoms and perpetrators) (62%). As one would expect from a psychologist who specialises in service provision for people in the general community, the majority of Counselling Psychologists work with all of the high prevalence mental health conditions in Australian society. A growing number of Counselling Psychologists go on to develop specialised skills in working with low-prevalence conditions (e.g., psychosis, dementia and eating disorders) due to their professional roles in private hospitals, mental health clinics and other psychiatric settings.

The current system discriminates against those who turn to a Counselling Psychologist when they are reaching out for help. Just as we agree in principle for the broader recognition of other mental health specialists in the Psychology discipline, we ask that policy-makers change the current system to include Counselling Psychologists. As stated previously, the ACP takes the position that there are two possible ways this could be achieved. First, the Government may instead offer an equitable rebate for all Australians accessing psychological services. Second, policy-makers could broaden the scope of inclusion to the top-tier, so that it is inclusive of other mental health specialists like Counselling Psychologists.

Flawed Economic Rationale for the Planned Cuts to Psychological Services

The ACP understands that part of the rationale for the planned cuts to *Better Access* are based on economic grounds, in that some critics have argued that people who are in the lowest quintile of the Index of Relative Socioeconomic Disadvantage (IRCD) receive less of a Medicare subsidy overall. Those defending the cuts claim that the wealthiest people receive the most psychological services, whereas those who are most disadvantaged receive the least. However, there are some fairly obvious problems with that interpretation of the available data. Firstly, IRCD does not measure income, but rather, it associates disadvantage in terms of the postcode where a person lives. The ACP urges policy-makers to be cautious about making generalisations about the disadvantage of a person on face value of the suburb where they live – especially in a nation like Australia. Our practitioners observe that many psychologically vulnerable people are cared for by family while they recover and others often do struggle with employment and a multitude of disadvantaging factors. In addition, we also see many disadvantaged people living in areas that are otherwise categorised as being middle-class suburbs.

Secondly, such claims do not align with the finding from the *Better Access* evaluation that the reason why over half of consumers who had not accessed psychological services previously was the cost associated with treatment (DoHA, 2011); nor do these claims match with large-scale surveys of practitioners indicating that a high proportion of psychologists bulk bill their clients, with many charging below the recommended schedule fee (APS, 2007). Again, we stress the importance of basing policy reform decisions on the best evidence available.

The economic rationale for the proposed cuts to psychological services relies on a flawed interpretation of the data. Overgeneralisations about the relative disadvantage of a mental health consumer on the basis of their suburb where they live should be avoided. We have much better data available from consumer feedback and practitioner surveys, indicating that the majority of people utilising services in the Better Access system would otherwise be unable to afford services without the high rates of bulk billing and low gap fees that are presently available in the scheme.

Conflict of Interest within the Mental Health Expert Working Group

The ACP is cognisant of the fact that many of the experts that were appointed to the recently formed 'Mental Health Expert Working Group' have a shared history together and an ideological stance against the *Better Access* scheme that dates back nearly a decade. In many instances, we have noted that these individuals oversee programs which will be the direct beneficiaries of funding that is being extracted from the *Better Access* scheme in the form of cuts to psychological services.

An example of the conflict of interest and the centralisation of power around just a few individuals, are the obvious connections between the authors of the 'blueprint' document used to justify the mental health reforms in the budget (Hickie et al., 2011). All of the authors for the blueprint document are connected in one way or another to the senior leadership of *Headspace* and *Orygen Youth Health*. The programs they are responsible for are the direct recipients of funding sourced from the cuts to psychological services in *Better Access*. We have heard from many people who see this as corruption on a large scale, particularly members of the public who have been led to believe that mental health care was a priority for the current Government. The argument that there are so few mental health experts in Australia that they are all associated with *Headspace* or *Orygen*, is a defence that does not stand up to critical inquiry. There are literally hundreds of other practitioners and academics of high standing in Australian society whose views are more representative and could be drawn upon to form a fair and balanced mental health expert group.

There have also been reports that the mental health expert advisory group was not consulted about the decision to cut psychological services in the *Better Access* program (Smith, 2011). Whilst this is worrying in itself, we note that at least one of the members of the group is on the record as having told the *Medical Observer* back in early February that funding should be taken from the *Better Access* initiative and re-directed into the ATAPS (Brill, 2011). The implication is that these cuts to psychological services were devised on the basis of a limited range of opinions, rather than the evidence from data in the evaluation of the *Better Access* scheme. Further to this point, the ACP is concerned that since the budget was announced, a small group of individuals with well-known links to the advisory group has been defending the cuts across medical journals (Rosenberg & Hickie, 2011) radio interviews (Adams, Hickie, & McAuliffe, 2011; Horowitz, 2011), and newspapers (Metherell, 2011), in some cases, mischaracterising those who utilise Better Access as 'the worried well'. We see this as a very stigmatising and misleading opinion to broadcast publically about vulnerable people in our society with an identified mental health disorder. Our main concern here is that policy agenda is being based on distorted and misrepresentative opinions coming from an isolated group of individuals who are well-known critics of the Better Access scheme. To our

knowledge there are practically no other people in the mental health sector calling for these cuts. In short, the decision to cut psychological services goes directly against both public and professional opinions about the need for maintained psychological services in Australia.

The ACP questions the independence of the Mental Health Expert Working Group, on the basis that the majority of the members of that group have a long-standing bias against the *Better Access* scheme and a conflict of interest towards funding their own projects. We do not believe that this is in the interests of the general public, or that these decisions are based on any sound empirical data. We are gravely concerned about reports that the expert group were not consulted about the cuts to psychological services, leading us to question whether the decision was made exclusively on the basis of the opinions of an isolated and unrepresentative minority. Whether it is the case that the Mental Health Expert Working Group just happens by chance to be comprised of people with the same ideological stance; or whether it is a case that the recent policy decision was the result of only a few opinions - the Australian public deserve better.

Mental Health Consumer Perspectives

Counselling Psychologists have a specific focus on the empowerment of people, at all levels of psychological functioning. For this reason, we have taken the stance in this issue that the voices of mental health consumers need to be brought to the forefront of the current issues around cuts to psychological services in the Medicare system. The ACP has contributed time and resources to gathering client perspectives about these cuts, through providing web-space, co-ordination, and technical expertise for those who wish to share their point of view.

Since early May, there have been over 4200 people who have signed our online petition calling on the Government to reverse the decision to limit psychological treatment to 10 sessions in the *Better Access* scheme. Collectively across the forums there have been over 1725 posts, mostly from mental health consumers, but also family members of consumers, concerned citizens, and a range of different mental health practitioners opposed to the changes. We strongly encourage the senators to visit the online petition and read some of the comments left behind by those who are opposed to the cuts. You can view each comment by putting the mouse over the word 'view' next to each person's name at the following website:

http://www.gopetition.com/petitions/better-access-to-psychologists/signatures.html

You may also wish to view a website that the ACP has assisted mental health consumers and practitioners to develop, challenging the cuts to psychological services. There you will find the personal stories of several individuals who have spoken out: http://www.betteraccess.net

Many Australians are concerned about these cuts to psychological services. Many people were not even aware of the proposed cuts, but provided with more information, the general sentiment has been one of shock and disbelief. This appears to be directly attributable to a campaign . A convincing campaign from the Government around their new spending on mental health has unfortunately resulted in many people not realising that these cuts were being proposed. Given that the core message was one of expanding mental health services, members of the public have expressed shock and a sense of disbelief. Other parties have been more concerned about 'robbing Peter to pay Paul' but we believe that the bigger issue is one of public trust. That is, if the Government tells the public that mental health is a priority, then cutting public access to psychological therapy does not live up to those words.

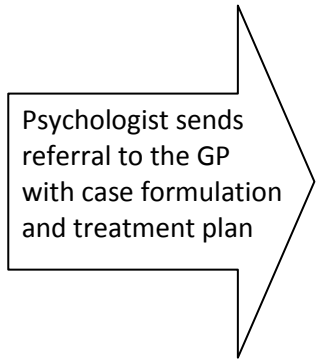
Appendix 1:

An alternative pathway for Medicare funded psychology items

Phase 1: Psychological Assessment

3 initial psychologist consultations

Direct access to a psychologist for up to 3 consultations to the purpose of mental health assessment without needing a GP referral. If only brief episodic care is required, access to psychological services concludes here. If ongoing psychological treatment is required, then a GP referral is necessary.



Rationale:
Some people may approach their GP about depression or other mental health conditions, whereas others will directly approach a psychologist when they reach out for help. When a person reaches out for help in a psychologically distressed state, their needs and interests ought to be appreciated. If there are people with mental health conditions who disengage from seeking help because the system is too complicated, then the system needs to be changed in such a way that the people who are most in need receive timely and appropriate psychological care. Psychologists have extensive training in providing comprehensive psychological assessment and diagnosis.

Evidence:
Research indicates that brief training of psychological methods to GPs has a limited relationship to clinical outcomes (Morgan et al., 1999). Clinical trials demonstrate no impact of training on competence and no relationship between perceived competence and actual clinical outcomes (King et al., 2002). This brings into question the practical value of brief training models for GPs providing psychological assessment.

Phase 2: Psychological Treatment

12 sessions of psychotherapy

GP approves 12 sessions of uninterrupted psychological treatment. In cases where fewer sessions are required the psychologist provides a termination report to the GP summarizing outcomes of the psychological treatment. Where further sessions are required, a report is provided to the GP requesting additional psychological support for the patient.

Rationale:
The standard protocol for psychological treatment remains at around 12 sessions. Although this limited form of intervention relies on the psychological condition being uncomplicated and the treatment being straightforward, the general outcome is that most people receive some psychological support in a time of significant distress.

Evidence:
A wide range of studies demonstrate that there is a statistically significant reduction in symptom severity after 12 sessions of brief therapy, including CBT, IPT and other psychological techniques (e.g., APS, 2010).

Phase 3: Additional Support

6 sessions of psychotherapy

Where further psychotherapy is required, the GP refers the patient for 6 further psychological services. The terminology is changed to 'additional support' to address the implication that people accessing services for up to 20 sessions are abnormal, reducing the stigma about seeking psychological support.

Rationale:
Going by recent evidence, the majority of people actually require close to 20 psychotherapy sessions to show lasting improvement. If this is the case for most people, then it stands to reason that we should not classify this length of treatment as being due to 'exceptional circumstances'.

Evidence:
Recent research indicates that for the majority of clients, close to 20 sessions of psychological therapy are required to maintain long-term stability of psychological distress (Harnett et al., 2010; Shea et al., 1992)

Appendix 2:

Open Letter to The Hon Mark Butler from Consumer-Driven Action Group

Association of Counselling Psychologists
Ben Mullings, ACP Chair, PO Box 1524, Subiaco 6904
e-mail: ben@psyber.net.au
Mobile: 0431870401
Fax: 08 9317 6166

13 June 2011

The Hon Mark Butler MP
PO Box 2038
Port Adelaide
SA 5015

Re: (Open Letter) Cuts to Psychological Services in the 'Better Access' program

Dear Mark Butler,

Following the release of the Commonwealth budget in May, there have been widespread public objections to the proposed cuts planned for the *Better Access to Mental Health Care* initiative. I was contacted by several of my colleagues and a large number of mental health consumers, requesting that we take action to raise awareness and communicate the concerns held by those who will be most affected by the decision to restrict psychological services. In the document that follows I have summarised the most serious of these objections, with the view that you will re-consider these cuts and overturn the decision.

To give you a sense of the scale of these concerns, since beginning this campaign just a few weeks ago, the group has been contacted by several thousand people from every area of mental health care. Not only has this included a large majority of consumers who have directly accessed services in the *Better Access* program, but also their children, their partners, their carers, and their extended family networks. We have also heard from hundreds of mental health practitioners, including psychologists, psychiatrists, social workers, general practitioners, mental health nurses, occupational therapists, and many others. It has been the case that the feedback received so far has stated that the there is no valid justification for these cuts, in the wake of claims from Government that mental health is being given just as much priority as physical health. The numbers of people involved in this action are growing daily and we understand that GPs are considering launching a much larger campaign than ours, aimed at drawing on millions of Medicare patients. We call on you to reverse your decision quickly, so that further time and energy does not need to be wasted on proving to the Government how seriously wrong these cut-backs are. We hope that the following pages make that clear to you as the Federal Minister for Mental Health.

It needs to be openly stated that everybody involved in taking action on this issue has welcomed new investment in mental health care that were announced in the budget. However, this should not come at the cost of existing programs that have been shown to work. Expecting positive results in half of the time, with no exceptions, does not show the public that investment in the mental health is seen as a worthwhile enterprise by our Government.

Sincerely,

Ben Mullings (Chair)
Association of Counselling Psychology

Cutting Psychological Services Increases Costs for the Public

From the outset, it must be noted that if the Government is sincere about identifying mental health care as an appropriate investment for Australian society, then it is appropriate for investment to be directed towards psychological services for people with high prevalence mental health disorders. Over a decade ago, the economic value of psychological services to GDP in Australia was calculated as providing an approximate 5-fold return on investment[1]. Mental health issues are one of the leading causes of disability in Australia[2], preventing people from contributing to the economy and forcing people to depend on support services[3]. In order to prevent unnecessary stays in hospital, tackle welfare dependence, increase productivity and optimise the income of Australians – psychological services must be given adequate support. An essential component of that is to ensure that those who have a recognised mental health disorder receive evidence-based levels of psychological treatment.

The current maximum cost to the taxpayer for 18 sessions of psychological services from a psychologist, social worker or occupational therapist, ranges between $1468.80 (generalists) to $2156.40 (clinical psychologists). Setting aside problems with the two-tiered system of practitioners, these costs are exceptionally low when they are weighed against the direct benefits of this investment.

The *Department of Health and Ageing* estimates that, by itself, the cost of one bed day in a specialist mental health facility in 2009 was $1002 alone. For those who need further psychological treatment because they are experiencing severe psychological distress, the psychological services provided in the *Better Access to Mental Health Care* initiative are considerably less expensive. The *Better Access* program supports people in usual and familiar settings, minimising disruption to a person's life and avoiding the risk of pathologising symptoms of distress. For some people, these services prevent them requiring a stay in hospital. This is essential to consider in the context of the well established links between depression and suicide.

As of June 2011, the *Disability Service Pension* for a single adult amounts to $670.90 per fortnight, whereas *Newstart* provides $474.90 per fortnight. Many Australians who struggle with depression, anxiety, and other common mental health disorders, require time off work or simply struggle to maintain stable employment[3]. Balancing the maximum cost of the *Better Access* program against these figures, the return of investment is paid for in its entirety when those accessing psychological services are able to maintain employment even for just 2 to 3 months in any given year. In addition, those who earn $30,000 PA already pay $1740 per year in taxes. Therefore, simply making the transition from welfare to work balances the cost of the psychological intervention. Further to this point, when an individual transitions from 30K to 50K, taxes increase to around $4,500; and likewise, when someone moves from 50K to 70K their taxes increase to around $11,000. Put simply, in many cases, funding psychological services maintains stability in employment for those with a mental health disorder and more than adequately returns the initial investment spent towards their mental health care[4]. Providing people with psychological services when needed helps them become active, maintain productivity, and optimises their contribution to the Australian economy[5].

Providing sub-standard levels of care for anxiety and depression, results in a wide array of serious secondary effects for many people in Australia. For those individuals who open up sensitive emotional

issues with a therapist and find that they have run out of sessions, deterioration in their mental state becomes a strong likelihood. This can have a direct impact on an enormous range of areas of that person's life[6]. Deterioration in a person's psychological state frequently result in family and relationship issues. People in this situation may attempt to self-medicate with alcohol or other substances and people with complex dual-diagnosis difficulties are at risk of relapse[7]. Parents who are unable to access psychological services for their mental health condition will struggle with family life. When sub-standard psychological care is the only option it can even lead to emotional and physical abuse, or family court appearances, at great cost to vulnerable people and our broader society[8]. When mental health issues are inadequately treated it can also result in situations that draw on the resources of police, or in crisis presentations at hospitals. When psychologically distressed people are crying out for help and they are cut off from services, it can lead to self-harm and suicide[9]. It must be remembered that problems such as these have far reaching consequences that extend well beyond the individual. The impact of mental health affects families, loved ones and entire communities. The negative outcomes mentioned above have an enormous cost in human suffering and directly impact on our economy.

It should also be pointed out that people with common mental health disorders, like depression, often lack self-care. Quite aside from the obvious costs outlined above, when we fail to support those who are experiencing depression, they often struggle to look after their physical health, let alone their emotional well-being. There are long-term medical consequences for this that the Australian tax-payer will ultimately end up having to pay for – all of which can be alleviated or prevented through the provision of timely psychological services[10].

It has been repeatedly proposed by the Government since the Commonwealth budget was released that consumers who require more than 10 sessions of psychological services will still be able to access a total of 50 sessions with a psychiatrist per year. Psychiatric services are clearly of high value to patients who are willing to take medication, however the cost of these services, ranging from $250 to $400 per consultation, are far more than the cost of services provided by psychologists and other mental health professionals. We can calculate the difference in cost using the Medicare schedule of fees to retain the upper limit of 18 sessions, for situations where a consumer has no other options other than to receive psychiatric rather than psychological services. By our calculations, those additional 8 sessions alone will cost at least $1315.20 through to $2468 per year on top of what it would otherwise cost for a psychologist to see the client. This figure obviously rises quite markedly for cases where a client may choose to access further consultations with a psychiatrist, from anywhere in the range of approximately $1250 through to $10,000 depending on the amount of sessions that are utilised.

Given the shortage of psychiatrists and the current 3 to 6 month waiting lists, we have strong doubts that mental health consumers will be provided with continuity of care, quite aside from the concern about how much more costly this treatment option is. We must also set aside that fact that there are no available psychiatrists in many regions of Australia[11], especially when we consider the plight of people living in remote locations. The proposal that the shortfall of psychological services can simply be taken up by psychiatrists will force many desperate people to spend large amounts of time and money travelling in a state of crisis when they need help, rather than accessing mental health practitioners in their local community. This also indicates policy misconception that psychology and psychiatry are functionally equivalent, involving the same treatments and so on, despite world-wide acknowledgement

of the discrete differences between each.

One of the unforeseen consequences of the proposal from Government to cap psychological services at the 10 session mark, is that there will be many consumers who will need to begin therapy all over again with a new practitioner, should they require additional support. This problem arises from the fact that in many cases, ATAPS providers are not the same practitioners as those who provide services in the Better Access program. We know from decades of psychological research that working alliances between a client and their therapist often require 5 sessions to stabilise[12]. Regardless of which practitioner group is utilised, it is a wasteful use of public money to require people to tell their story over from the beginning again and re-establish trust with a new practitioner, when the Government could simply allow the client to see their trusted therapist over a more realistic period of time in the first instance. In any case, we point out that by forcing consumers to start again with a new mental health practitioner, it is highly likely that distressed people will disengage from the system and no longer access appropriate treatment[13]. If this were to occur it will add to the costly negative outcomes mentioned above, in terms of draining the hospital system, the legal system, law enforcement, drug abuse services and crisis care.

The fee-for-service arrangements that are in place for the *Better Access to Mental Health Care* initiative currently allow Medicare funds to be focused on genuine psychological services for mental health consumers. The suggestion that funding will be diverted through the ATAPS scheme and other programs, could potentially result in NGOs being able to expend public funding on administration, committee meetings and other functions that do not result in clients receiving psychological services. With less of the money being directed to psychological services for mental health consumers, it is doubtful that this will be a cost effective use of Commonwealth funds. In short, the new proposals create a situation where public funds can be siphoned out of mental health care.

Summary:

Mental health disorders are ranked amongst the highest contributing factors to the burden of disease in Australia, with anxiety and depression being the leading cause of years lost due to disability amongst the various disorders[2]. The *Better Access to Mental Health Care* initiative directly targets people with depression and anxiety and all of the available evidence shows that in approximately 80% of cases the program reaches people with moderate to severe levels of distress. Evaluations show that the *Better Access* program provides cost-effective treatment for those who in the majority of cases have never accessed mental health care in the past[14]. Other treatment alternatives for these mental health disorders have been shown to be far more expensive to deliver equivalent psychological services. The proposed changes will result in less public money being directed towards actual psychological services for those who need them, and more funds being re-directed towards administrative functions. In short, the Government cannot have it both ways on this issue. If on the one hand there are so few people with mental health disorders who access more than 10 sessions of psychological services, then the proposed cut-backs will not produce significant savings. If on the other hand there are significant cost savings to be had by these cut-backs, then it stands to reason that there are a significant proportion of people who are presently utilising these valuable mental health services. When it comes to the mental health of our population, the return on these investments is unquestionable. The only real question is whether the Government considers mental health care a worthwhile investment for our population.

This Policy Obstructs Mental Health Consumers

The new position of the government that mental health care can be provided through psychological services in under 10 sessions, undermines the fundamental basis of the *Better Access* program. That is, when this program was conceived, the central purpose was to deliver evidence-based psychological interventions to people with an identified mental health disorder. The aim was to provide members of the public with scientifically valid treatment options. The length of treatment that was initially proposed was based on controlled studies in evidence-based practice, showing that 15 to 20 sessions of psychological interventions are required. A review of the research was commissioned by the *Department of Health and Ageing*[17], which established the appropriate length of treatment for the purposes of the *Better Access* program was 12 to 18 sessions. It would now seem however, that the Government is ignoring the evidence-based research and obstructing mental health consumers from accessing appropriate levels of psychological support for their conditions. These proposed changes to the *Better Access* program result in measurably 'worse access' for mental health care consumers.

Aside from the fact that the maximum number of sessions has been nearly halved, there are quite a number of other ways that these changes will fragment service provision in Australia. Adding time limitations for GPs at the point of referral will increase inaccuracies in the initial assessment. Although there are some GPs who have extensive training in mental health assessment, the minimum length of training in this area remains low. Limiting the amount of time that GPs can see patient for the initial assessment and referral is going to make it harder for those who have less training in mental health assessment to provide an accurate referral. Applying pressure at the point of referral will increase the amount of inappropriate referrals beyond what would otherwise occur by chance. Mental health consumers and practitioners have voiced their concerns that GPs may become less inclined to refer to the *Better Access* program as a result of the unrealistic expectations that are being built into the system. There is in fact already evidence that GPs are refusing to refer patients through the *Better Access* scheme since the Government announced these changes.

Splitting services at the 6 and 4 session mark in the *Better Access* program also creates an additional layer of fragmentation to the system. Under the current arrangements, psychological services are broken down into 6 session clusters, making it easier for clients and practitioners to track when another GP referral is needed. The arbitrary benchmark of 6 and then 4 sessions, seems to be meaningless and bureaucratic. To the view of the author and other psychologists who have been consulted, there are no known studies that would suggest that therapy is optimised by reviewing the process at the 6 or 10 session mark. This will ultimately confuse mental health consumers and cause premature termination for those accessing much needed psychological care. This will also add to confusion about when reports are due, which will impact on levels of communication between practitioners.

With a mere 10 sessions available, many consumers will question whether it is worthwhile to even begin talking about complex issues. Those who have severe mental health issues will know that 10 sessions is grossly insufficient to work through complicated psychological issues. In effect, this will mean that only high income earners will be able to benefit from the *Better Access* scheme. That is, those who earn a high income will be able to afford more appropriate levels of psychological treatment that approach evidence-based levels of care. For those who are most disadvantaged, having a mere 10

sessions available to them will inevitably create pressure to choose medication rather than opting for psychological treatment. In effect this change in policy severely restricts the options available for low income earners and reduces self-determination about preferred treatment options.

The *Better Access* initiative has allowed psychological service providers in regional and remote areas to offer Government-subsidised services to local people. With the proposed policy-shift towards agency-based services at *Headspace*, *EPICC* and so on, there will naturally be a resulting move away from the local access that was previously available for people in rural and regional Australia. Service provision in large centres benefits a select cohort living in densely populated areas, however, this should not come at the cost of psychological care in geographically distant locations. It is unacceptable to rely on web-based approaches as a replacement for face-to-face services in remote locations[15], especially when we currently have programs in place that allow for practitioners in distant locations to offer high-quality psychological services in a cost effective way. On top of the cost-shifting away from services in remote areas, the proposed change in policy will inevitably result in increased travel costs for people who will be forced to access centre-based services in more populated regions.

The unrealistic expectations of Government about what can be achieved in 10 sessions of psychological services lends towards a misleading impression that a patient should be fully recovered in 10 sessions. None of the psychological research shows that therapeutic gains can be maintained or that relapse can be prevented by terminating therapy at that mark. Cutting off access for consumers to a level that is below minimum treatment guidelines, directly impacts on the level of early intervention that can be provided. Some consumers and practitioners may be forced to span out appointments over longer periods of time, in order to monitor the client and prevent them from severe levels of deterioration. Spacing appointments further apart will result in less effective treatment.

Individuals who begin therapy with complex presentations will suffer as a result of these proposed changes. If for example, a client began therapy with childhood trauma, self-esteem issues, tension at work, relationship problems, sleep issues, and so on, then in the first instance they are going to struggle to articulate this in a coherent way to their referring GP. Knowing there are only 10 sessions available in advance, people are going to have a very hard time identifying which issues they can realistically work on over such a brief period of time. Practitioners are going to be put in the compromising position of singling out one issue to work on, hoping to make enough gains over a short period of time to help that client continue to cope on their own when they are suddenly cut off from accessing further support. This is an artificial position to take which will severely impair the effectiveness of treatment available for Australians with severe or complex presentations, co-morbidities and dual-diagnosis[16].

For those who develop a relationship of trust with their practitioner, the issue is going to be made worse by the fact that after they have consumed the maximum 10 sessions covered by Medicare, there are not going to be any other options available for ongoing psychological treatment. The flexibility of the *Better Access* program has allowed consumers to access the practitioner that they would prefer to consult with, rather than being forced to accept a pre-designated professional. Self-determination has been an integral component of the new health system outlined by Government papers on mental health care over the last decade, and yet, the new proposed cut-backs restrict options for clients to choose a trusted mental health professional. This represents a major setback for Australian health policy.

Summary:

Individuals who have a mental health disorder often struggle to cope on their own for many years before they finally decide to reach out for help. Australians value self-sufficiency and resourcefulness, but at the same time, our people honour the efforts of each individual to improve their lives and make a difference to our communities. When someone reaches out for help, the Government has a role to give them a fair go at turning their life around. The proposed cut-backs to psychological services will create more barriers for those who have a mental health disorder. The changes fragment the system, cause further disconnection and isolation for people in regional areas, and undermine the decisive judgements that individuals make about what kind of mental health care they need. Put simply, the barriers that are being proposed will make life measurably harder for people who are already struggling to cope. Cutting short psychological treatment leaves distressed people in the lurch. We think this is a poor way to treat those with a mental health disorder and we believe that the rest of Australia will agree with us on that point.

The Proposed Reforms Stigmatise Mental Health Care

During this campaign, we have heard from thousands of mental health consumers who have utilised services through the *Better Access* program highlighting the way that the proposed cut-backs will stigmatise the act of asking for help in the form of psychological services. The single most valuable outcome of the *Better Access* program has been that affordable and evidence-based psychological services have become accessible to people who need them. The fee-for-service structure of the *Better Access* program has meant that consumers can receive services in their own communities, retaining a sense of personal dignity, regardless of their circumstances. The shift towards funding NGOs to provide agency-based services, or requiring people to see a psychiatrist rather than a psychologist, represents a significant departure from the purpose of the program. The *Better Access* program in its current form is far more flexible, in that it allows people to access care in a private and discrete manner, without the drama of going to a large agency or being coerced towards relying purely on medication and case management. There are a great many people who do not wish to become dependent on medication to address their mental health disorder and they should be supported in their decisions about how best to manage their condition wherever possible. Australians should not face more restrictions than other advanced nations to accessing both psychological and psychiatric treatment approaches.

It seems appropriate to state plainly, for the sake of educating the reader, that it is not appropriate to medicate every person who has a mental health disorder. Psychological interventions have been shown to be as effective in the treatment of high prevalence mental health disorders as any medication. No single treatment approach works for every type of psychological problem and not all people will respond to a specific treatment targeting a specific disorder. When people are not given other options or they do not wish to be medicated, they typically refuse to comply with the treatment. Consumers are understandably quite concerned that by cutting short psychological treatment, the Government is pressuring them to take medication in cases where: (a) they have no intention of taking medication, and (b) they do not find medication to be helpful or appropriate for their condition. The issue is that by taking away psychological treatment options and suggesting people see a psychiatrist instead, the

Government is creating pressure for consumers to take a pill rather than empowering them to reflect and make positive changes to their lives. Both treatment options need to be available and there is no reason why these approaches cannot both be used in harmony with one another.

The session structure of the proposed new system implies that patients should improve after just 6 appointments, creating unwarranted pressure for people to simply "get over it" quickly, rather than working through the genuine source of their psychological problems. Consumers quite aptly point out that people with mental health disorders often find it difficult to accept that they need help in the first place. It can take many years for someone to decide that they are ready to talk to a psychologist, so when a person finally does make that decision to reach out for help, offering them an unrealistically short length of treatment implies that if they require longer than that amount there is something abnormal going on. There are an enormous amount of controlled studies and research about relapse prevention that shows that 6 to 10 sessions is plainly inadequate for the 80% of people who access the program with moderate to severe presentations. More to the point though, mental health consumers and their families are speaking out on this issue, saying that the proposed cut-backs to the *Better Access* program are negligent and are likely to cause significant harm and disruption to their lives.

The bottom line for most people utilising services through *Better Access* is the cost of seeking help. Consumers have shared their stories throughout this campaign, explaining that they simply won't be able to access psychological services if the proposed cut-backs went ahead. Some report struggling towards independence following trauma and victimisation, family breakdown, and all the while, raising children as a sole parent. Scenarios such as these are commonplace in the *Better Access* program, and they illustrate how removing psychological services will do measurable damage to the lives of those who are already struggling. The implication that people who are struggling on so many fronts can simply turn their life around completely in 6 to 10 sessions per calendar year is plainly unrealistic. It takes time for people to reflect and change their lives. This is not a process that can or should be rushed by policy-makers. Pressuring people with a mental health disorder to work through their problems quickly is insensitive. Sentiments of this nature are at the heart of the stigma that Australians experience when they reveal a mental health concern. As such, misconceptions about the value of artificially abbreviated psychological treatment should not be embedded in Australian health policy.

Summary:

There is no quick fix to the treatment of mental health disorders. The position of the Government that the most widespread mental health problems can be fully treated in just over 2 months, is nonsensical. Capping psychological services at 10 sessions per calendar year, with no exceptions, will set many people up for failure. For an individual who has a mental health disorder, it takes time to work through all of the relevant underlying problems they are experiencing and to make appropriate and lasting changes to their life. Rushing the treatment of mental health disorders is irresponsible and implies to those who are undertaking psychotherapy that if they don't get better in under 10 sessions, their case is abnormal. This is not the case and the Government should not be claiming that it is the case. The Government must be more realistic about the amount of psychological services that are needed by those who access this program in order to avoid stigmatising those people who seek help for a mental health condition.

The Proposed Cut-Backs Ignore the Evidence

The APS review of evidence-based psychological interventions is the most comprehensive overview of controlled studies in psychological research that has been published in Australia[17]. This review carefully assessed evidence from randomised controlled trials where specific psychological treatment approaches were applied to the treatment of people with specific mental health disorders, isolating treatment factors and examining how many sessions are required to produce statistically significant reductions in the severity of symptoms. This approach to setting evidence-based treatment guidelines aligns with similar efforts in both the USA and in the UK, and is widely regarded as being the gold standard for controlled research. The APS review identifies that 15 to 20 sessions of cognitive-behaviour therapy (CBT) and interpersonal therapy (IPT) are required for high prevalence mental health disorders like depression and anxiety. Given that this review was funded by the tax-payer and set the benchmark for the prior 12 to 18 session limit on *Better Access*, it is surprising that policy-makers are now claiming that 10 sessions of psychological treatment are sufficient.

Similarly, the national depression initiative *BeyondBlue* has released two booklets entitled 'A Guide to What Works for Depression'[18] and 'A Guide to What Works for Anxiety Disorders'[19], which both identify that 15 to 20 sessions of CBT and IPT are needed for the treatment of these common mental health conditions. This consistent finding from reviews across Australia and internationally, goes directly against the proposed new mental health policy. It would appear that those who created the new policy did not adequately consider the existing scientific evidence in the field of psychology. Instead, it would seem that they have relied on a simple interpretation of frequencies, where clients with a mixed range of problems were lumped together, as though there are no differences between various mental health disorders, calculating an average number of sessions that were used without regard for any other relevant treatment factors. Crude generalisations about the optimal number of appointments cannot fairly be drawn from an uncontrolled study like the *Better Access* evaluation.

To illustrate the problem, we can use the analogy of providing antibiotics in general practice. If there were an evaluation showing that patients only used half of the antibiotics they were prescribed by their GP, this would not justify halving the dose of antibiotics for members of the public. If we were to find that only half of the prescribed dose were used by patients, when we know from controlled studies that patients need a full dose, then it would be intellectually dishonest to claim that only half a dose should be provided. Halving the dose would be irresponsible and would put the public at risk of harm – and the same principle applies with psychological interventions. If the Government is sincere about making the treatment of mental and physical health equivalent, then they must accept that cutting psychological services down to 10 sessions is also irresponsible and will put the public at an increased risk of harm.

Although randomised controlled trials demonstrate that 'statistically' significant differences can be achieved in 15 sessions for common conditions, more rigorous standards of research show that we need closer to 20 sessions of psychological treatment to attain 'clinically' significant levels of improvement[20]. The difference between these two technical terms is that whilst figures of symptom severity may improve temporarily in a study like the *Better Access* evaluation, momentary symptom relief doesn't necessarily translate into reliable or clinically significant levels of improvement. A controlled study was published in Australia only last year, which indicated that after 10 sessions of psychological services

around half of patients needed further treatment[20]. In a large sample, these researchers found that for 85% of people to show reliable improvement, they would need at least 20 sessions of psychotherapy. These figures are essential to consider in relation to relapse prevention. It will not do to simply alleviate symptoms temporarily, applying some kind of 'psychological panadol' making the pain go away for a while. Australian society deserves a more sustainable solution that addresses the underlying problem.

Setting aside the limitations of the *Better Access* evaluation, the conclusions were overwhelmingly positive, despite the claims of apologists for the proposed cut-backs. The executive summary of the evaluation sums it up[21] (page 2):

> *There is good evidence that Better Access has improved access to mental health care for people with common mental disorders. Uptake of Better Access services has been high in absolute terms, even among relatively disadvantaged groups in the community. Better Access is not just catering to people who were already in receipt of care and/or who have relatively mild symptoms; it is reaching significant numbers of people who have not previously accessed mental health care; and it is providing treatment for people who have severe symptoms and debilitating levels of distress.*
>
> *Consumers are generally positive about Better Access as a model of service delivery and they appreciate the clinical care they have received. They are also reporting positive outcomes as assessed by reductions on standardised measures of psychological distress, depression, anxiety and stress. In the main, these outcomes are related to clinical and treatment factors rather than socio-demographic characteristics. Preliminary analysis of outcome and cost data for consumers seen by psychologists through Better Access suggests that the initiative is providing good value for money; equivalent data were not available for consumers seen by other provider groups.*
>
> *These achievements do not seem to be occurring at the expense of other parts of the mental health system. The numbers of allied health professionals in public mental health services have continued to rise, despite the attraction of working as private practitioners in the primary mental health care sector. In fact, Better Access may have had a positive effect on the way in which the Australian mental health workforce operates, with some indications that providers are engaging in more collaborative care.*

These statements are completely at odds with the claims of spokespeople for the Government who have attempted to justify these services being dismantled. The claim from Government spokespeople that the *Better Access* program is failing hard-to-reach groups and that those with moderate to severe mental health disorders would be better referred to other services, just doesn't stack up against the evidence. The APS was correct to point out that the *Better Access* initiative has been the most successful mental health program in the last 30 years. The proposed cut-backs damage this successful program and seem to be focused squarely on cost cutting rather than genuine investment in mental health care.

Each time that public attention has been brought to bear this issue, Government spokespeople have quickly contacted the media with misleading statements to the effect that the decision is based on "solid data" . Such claims generate a false impression that the announced cut-backs are founded on evidence-based principles. In fact, the "solid data" is merely a reference to the figures from a single study commissioned by the Government that did not factor in any of the normal controls used in mental health research. Instead, the *Better Access* evaluation lumped together all mental health disorders, as though every condition were exactly the same, without including any follow-up measures whatsoever.

In medical research, this would be akin to lumping together the common cold with cancer, along with every other medical condition, then drawing the bogus conclusion that if the average patient only sees a medical professional 3 times a year, then there should be no exceptions for people who need further appointments. In terms of the lack of follow-up data, the unsubstantiated conclusions of policy-makers about the *Better Access* evaluation are akin to saying that if patient shows initial signs of symptom relief, then the medical problem is over and done with. We know from decades of research that when you fail to deliver adequate levels of treatment for any illness or disorder, problems often resurface and get worse for a patient – and mental health is no exception to this rule.

Further to the issue of making misleading claims to the public, policy-makers have also cited that these cut-backs are endorsed by "independent expert advice". In truth, the 'expert advice' being referred to is a panel that was appointed by the Government, which is comprised of the chief beneficiaries of those funds that are being diverted away from the *Better Access* program. To the view of most sensible people, this amounts to a conflict of interest, therefore describing such expert advice as being 'independent' is highly dubious.

To put it bluntly, the Government appears to be engaging in a campaign of spin to justify these harsh cut-backs to psychological services, rather than dealing with all of the facts on the table. Decades of research about mental health care from controlled studies that show 10 sessions of psychological services are inadequate to treat depression and anxiety – the main target of the *Better Access* initiative. Despite any advice that the Government has received, there are decades of randomised controlled trials demonstrating that more than 10 sessions are required[17]. The Government should not be ignoring scientific evidence, especially when these findings have been repeatedly verified and are recognised worldwide.

These cut-backs amount to politicians assuming the role of clinical decision-makers, without any of the ethical responsibilities that practitioners face on a day-to-day basis. The policy changes are discrediting to the expertise and clinical judgement of mental health professionals. They undermine well-established benchmarks of evidence-based practice in mental health care. We believe that the Australian people do not accept that policy-makers should take on that role, nor would they knowingly accept policy that goes directly against such a large amount of scientific evidence.

Summary:

The Australian people expect mental health policy decisions to be intelligent and adequately informed. The proposed cut-backs to the *Better Access* program do not meet that criteria. All of the evidence from rigorous scientific research has repeatedly demonstrated that 10 sessions of psychological treatment is inadequate, especially for those who we know utilise the *Better Access* program, namely, those with moderate to severe mental health disorders. Replicated studies have established that it takes 15 to 20 sessions of psychological intervention to produce lasting improvement for around 85% of cases. It is unacceptable for the Government to rely on the opinions of only a small group of selected individuals in favour of cutting back services, particularly when those people are the beneficiaries of the proposed changes. It is equally unacceptable to draw on the findings of a single evaluation that did not control for any of the usual treatment factors in mental health research and lacked follow-up data of any kind. We insist that the Government implements mental health policy that is firmly based on evidence from replicated and controlled studies. Although there is considerable room for expansion of the *Better Access* system (such as resolving the problems of the two-tiered system), for the time being, allowing for 12 to 18 psychological services per calendar year in the *Better Access* scheme approaches minimum benchmarks for evidence-based practice.

References:

1. Patrick, J. (2005). The economic value of psychology in Australia: 2001. *Australian Psychologist, 40*(30), 149-158.
2. Australian Institute of Health and Welfare. (2007). The Burden of Disease and Injury in Australia 2003. Australian Government.
3. Australian Bureau of Statistics. (2008). Survey of Mental Health and Well-Being of Adults: Summary of Results, 2007. Australian Government.
4. Layard, R. (2006). The case for psychological treatment centres. *British Medical Journal, 332*(7548), 1030-1032.
5. Hilton, M. F., Scuffham, P. A., Vecchio, N., & Whiteford, H. A. (2010). Using the interaction of mental health symptoms and treatment status to estimate lost employee productivity. *Australian and New Zealand Journal of Psychiatry, 44*(2), 151-161.
6. McMurran, N., Huband, M., & Overton, E. (2010). Non-completion of personality disorder treatments: A systematic review of correlates, consequences, and interventions. *Clinical Psychology Review, 30*(3), 277-287.
7. Farren, C. K., & McElroy, S. (2010). Predictive factors for relapse after an integrated inpatient treatment programme for unipolar depressed and bipolar alcoholics. *Alcohol and Alcoholism, 45*(6), 527-533.
8. Jewell, L. M., & Wormith, J. S., (2010). Variables associated with attrition from domestic violence treatment programs targeting male batterers: A meta-analysis. *Criminal Justice and Behavior, 37*(10), 1086-1113.
9. Tarrier, N., Taylor, K., & Gooding, P. (2008). Cognitive-behavioral interventions to reduce suicide behavior: A systematic review and meta-analysis. *Behavior Modification, 32*(1), 77-108.
10. Moussavi, S., Chatterji, S., Verdes, E., Tandon, A., Patel, V., & Uston, B. (2007). Depression, chronic diseases, and decrements in health: results from the World Health Surveys. *The Lancet, 370*(9590), 851-858.
11. Schweizer, Y., Spratt, C., & O'Connor, D. W. (2009). Expanding Australian psychiatry training settings beyond metropolitan public hospitals: background and issues. *Australasian Psychiatry, 17*(5), 389-393.
12. Norcross, J. C. (2002). Empirically supported therapy relationships. In J. C. Norcross (Ed.), *Psychotherapy Relationships That Work.* London: Oxford University Press.
13. Zuroff, D. C., & Blatt, S. J. (2006). The therapeutic relationship in the brief treatment of depression: Contributions to clinical improvement and enhanced adaptive capacities. *Journal of Consulting and Clinical Psychology, 74*(1), 130-140.
14. Department of Health and Ageing. (2011). *Evaluation of the Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule initiative.* Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-ba-eval
15. Postel, M. G., de Haan, H. A., & De Jong. C. A. G. (2008). *Telemedicine and e-Health, 14*(7), 707-714.
16. Merkes, M., Lewis, V., & Canaway, R. (2010). Supporting good practice in the provision of services to people with comorbid mental health and alcohol and other drug problems in Australia: describing key elements of good service models. *BioMed Central Health Services Review, 10*(325). Retrieved from http://www.biomedcentral.com/1472-6963/10/325

17. Australian Psychological Society. (2010). Evidence-based Psychological Interventions in the Treatment of Mental Health Disorders: A Literature Review. Melbourne: Australian Psychological Society, Ltd.
18. BeyondBlue. (2009). *A Guide to What Works for Depression.* Retrieved from http://www.beyondblue.org.au/index.aspx?link_id=&tmp=FileDownload&fid=1406
19. BeyondBlue. (2010). *A Guide to What Works for Anxiety Disorders.* Retrieved from http://www.beyondblue.org.au/index.aspx?link_id=7.980&tmp=FileDownload&fid=1747
20. Harnett, P., O'Donovan, A., & Lambert, M. J. (2010). The dose-response relationship in psychotherapy: Implications for social policy. *Clinical Psychologist, 14*(2), 39-44.
21. Department of Health and Ageing. (2011). *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative: summative evaluation.* Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-ba-eval-sum

Appendix 3:

Domains of Knowledge – APS College of Counselling Psychologists

Domains of Knowledge – APS College of Counselling Psychologists

Areas	Inclusion Criteria
1. Theories and knowledge relevant to psychological specialities	Demonstrated advanced knowledge in: • Empirically Supported Treatments (ESTs) in psychotherapies • Group processes and family functioning • Normal and abnormal development across the lifespan Demonstrated advanced knowledge of: • Theories of personality development • Theories of lifespan development and their contextual relevance in psychotherapy & counselling • Diagnostic classification systems including DSM & ICD, and indigenous psychologies
2. Assessment	Demonstrated advanced knowledge in: • Formulation and diagnosis of client stressors, mental health disorders and psychological distress • Collaborating with clients in case formulation of mental health problems Demonstrated competence in specific areas of psychological assessment including: • Psychopathology • Bio-psycho-social status • Cognitive functioning and impairment • Personality • Vocational psychology • Health and well-being and tests of specific functioning
3. Interventions and implementation	Demonstrated advanced competence in: • Empirically supported therapies which facilitate change for individuals, couples, families and groups from a diverse range of backgrounds • Psychotherapeutic interventions • Integration of psychotherapy strategies from a diverse range of counselling theories • Taking account of contextual factors in designing and delivering psychotherapy interventions • Developing and delivering collaborative therapeutic interventions

Domains of Knowledge – APS College of Counselling Psychologists

Areas	Inclusion Criteria
4. Research & evaluation	Demonstrated competence in measuring and evaluating psychotherapeutic outcomes including: • Symptom reduction • Well being • Case formulations and reformulations • Psycho-educational outcomes • Resource provision and use Demonstrated competence in: • Conducting psychotherapy outcome research in quantitative, qualitative, or mixed mode forms. • Performing programme evaluations • Ongoing reflective practice • Routine inclusion of research in practice activities
5. Professional practice	Demonstrated ability to practice within an ethical framework in a variety of professional therapeutic and counselling settings. Demonstrated competence in: • Working with clients collaboratively to achieve therapeutic outcomes. • Recognition of the primacy of the Therapeutic Alliance in working with clients. • Demonstrated competence in working with other professionals. Demonstrated capacity to learn from, contribute to, and develop supervision in the context of professional practice.
6. Non-psychological components	Demonstrated competence in collaborating with allied professionals and other stakeholders in the mental health field. Well developed competence in developing alliances with consumer groups in the mental health field.

References

Adams, P., Hickie, I. B., & McAuliffe, C. (2011). *Mental Health and General Practitioners* [Audio Podcast]. Retrieved from http://www.abc.net.au/rn/latenightlive/stories/2011/3273683.htm

American Psychological Association. (1999). Archival description of counseling psychology. The Counseling Psychologist, 27, 589-592.

Australian National Audit Office. (2011). Review of the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program. Retrieved from http://www.anao.gov.au/~/media/Uploads/Audit%20Reports/2010%2011/201011%20Audit%20Report%20No51.pdf

Australian Psychological Society. (2007). 'Better Access' to Medicare Mental Health Items and Psychology Providers. Retrieved from http://www.psychology.org.au/Assets/Files/MBS_Report_Final.pdf

Barak, A., Hen, L., Boniel-Nissim, M., & Shapira, N. (2008). A comprehensive review and a meta-analysis of the effectiveness of Internet-based psychotherapeutic interventions. *Journal of Technology in Human Services, 26,* 109-160.

Brems, C., & Johnson, M.E. (1996). Comparison of Phd programs in clinical and counselling psychology. The Journal of Psychology, 130, 485-498.

Brems, C., & Johnson, M.E. (1997). Comparison of recent graduates of clinical versus counselling psychology programs. The Journal of Psychology, 131, 91-99.

Brems, C., Johnson, M. E., & Gallucci, P. (1996). Publication productivity of clinical and counselling psychologists. Journal of Clinical Psychology, 5, 723-725.

Brill, D. (2011, 8 February). Shift mental health funding: expert. *Medical Observer*. Retrieved from http://www. medicalobserver.com.au/news/shift-mental-health-funding-expert

Carey, T. A., Rickwood, D. J., & Baker, K. (2010). Tying up some loose ends: A rejoinder's rejoinder. Clinical Psychologist, 14(1), 70-71.

Council of Specialties in Professional Psychology. (2009). Counseling Psychology: Formal Specialty Definition. Retrieved from http://cospp.org/specialties/counseling-psychology

Department of Health and Ageing. (2010). Outcomes and proposed next steps: Review of the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program. Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/content/8573A6A3FAB3595BCA257700000D8E78/$File/review.pdf

Department of Health and Ageing. (2011). *Evaluation of the Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule initiative.* Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-ba-eval

Giese, J., Littlefield, L., & Mathews, R. (2008, June). Survey of Members Providing Medicare-funded Services Under the Better Access Initiative. *InPsych: The Bulletin of the Australian Psychological Society, 30*(3), 36-37.

Grant, J., Mullings, B., & Denham, G. (2008). Counselling Psychology in Australia: Past, present and future – part one. *The Australian Journal of Counselling Psychology, 9*(2), 3-14.

Greenberg, S., & Jesuitus, L. (2003). Study of the practice of licensed psychologists in the United States and Canada. New York: Professional Examination Service.

Greenberg, S., Smith, I. L., & Muenzen, P. (1996). Study of the practice of licensed psychologists in the United States and Canada. New York: Professional Examination Service.

Harnett, P., O'Donovan, A., Lambert, M. J. (2010). The dose response relationship in psychotherapy: Implications for social policy. *Clinical Psychologist, 14*(2), 39-44.

Horowitz, K. (2011, 16 July). *Gillard cuts psychology rebates* [Audio Podcast]. Retrieved from http://2ser.podomatic.com/entry/index/2011-07-16T06_46_25-07_00

Mallen, M. J., & Vogel, D. L. (2005). Introduction to the major contribution: Counseling psychology and online counselling. *The Counseling Psychologist, 33*(6), 761-775.

Metherell, M. (2011, 15 July). Mental health scheme is 'welfare for the wealthy'. *Sydney Morning Herald.* Retrieved from http://m.smh.com.au/lifestyle/lifematters/mental-health-scheme-is-welfare-for-wealthy-20110714-1hg52.html

Murdock, N.L., Alcorn, J., Heesacker, M., & Stoltenberg, C. (1998). Model training program in counseling psychology. The Counseling Psychologist, 23, 658-672.

NHS Careers. (2011). Counselling psychology within the NHS. Retrieved from http://www.nhscareers.nhs.uk/details/Default.aspx?Id=449

Orrum, M. (2005). Counselling psychologists in Western Australia: Roles, functions, settings, and professional identity. Curtin University of Technology: Master of Psychology: Dissertation.

Rosenberg, S. & Hickie, I. B. (2011). Were the budgetary reforms to the Better Access to Mental Health Care initiative appropriate? — No. *Medical Journal of Australia, 194*(111), 595.

Shea, T., Elkin, I., Imber, S., Sotsky, S., Watkins, J., Collins, J., Pilkonis, P., Beckham, E., Glass, D., Dolan, R., Parloff, M. (1992). Course of depressive symptoms over follow-up: Findings from the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Archives of General Psychiatry*, *49*(10), 782-787.

Smith, P. (2011, 27 July). Mental health expert panel frozen out. *Australian Doctor*. Retrieved from http://www.australiandoctor.com.au/login.asp?redirect=%2Farticles%2F92%2F0C071B92.asp%3F

Spek, V., Cuijpers, P., Nyklicek, I., Riper, H., Keyzer, J., & Pop, V. (2007). Internet-based cognitive behaviour therapy for symptoms of depression and anxiety: a meta-analysis. *Psychological Medicine, 37*, 319-328.