26th July, 2011

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

Dear Senator,

Re: Government proposal to cut the 'Better Access to Mental Health Initiative' to 10 sessions.

As a Senior Clinical Psychologist of more than 10 years experience, employed both in the community mental health system and operating a private practice, I am writing to express my objection to two matters (1) The Government's proposed changes to the *Better Access to Mental Health Care Initiative* (*'Better Access Initiative'*) as announced in the 2011 Federal Budget, and (2) the Government's consideration of abolishing the current 'two-tiered' system of Medicare Rebates to psychologists. I will address each issue in turn.

(1) The Government is proposing a change to the *Better Access to Mental Health Care Initiative*, effective of November 1st 2011, that will see the yearly maximum allowance of sessions of psychological treatment available to people with a recognised mental health disorder reduced from 18 to 10 sessions.

(a) The Medicare Evaluation has shown that the vast majority of clients only used 10 sessions. Firstly, there are a number of methodological issues with this evaluation which have been noted by the Australian Psychological Society, which I will mention later in point (c). But these results, taken at face value, still attract significant concerns in relation to reducing rebated sessions.

A strong body of scientific evidence demonstrates that clinical psychological intervention requires at least 12, and in some cases up to 30 or more, sessions for effective treatment of severe and complex psychological disorders. Unfortunately, psychological treatment is not a 'magic wand'. It takes time. With the current state of psychological evidence, it's just not how it works. Therefore, those with the most severe or complex issues (e.g., those with complex obsessive-compulsive disorder, those with severe depression with suicidal features, those with complex personality issues) will be most disadvantaged, either financially, or worse, unable to continue with treatment. We wouldn't arbitrarily cap a surgeon's time in completing a major surgery; we wouldn't arbitrarily cap a consumer's time in taking an essential medicine; why would we arbitrarily (without support from evidence) reduce rebateable psychological sessions from 18 to 10?

In an era of 'evidence-based' practice across various industry (including Government and Health), I am unclear at to what 'evidence-base' those consulting for the Government are referring to? The proposed cuts to the *'Better Access Initiative'* reflects the Federal Government's lack of understanding of the Clinical Psychology evidence-base, the nature of

clinical psychological therapy, and the specific and varied needs of Australians with mental health disorders.

(b) Those presenting with only mild presentations are unlikely to be affected by the cuts to session numbers. The treatment of disorders in the moderate to severe range is the unique specialised training of the Clinical Psychologist and, to undertake a comprehensive treatment of these individuals, more than thirty sessions per annum are sometimes required. In this way, Clinical Psychologists should be treated as Psychiatrists are under Medicare as both independently diagnose and treat these client cohorts within the core business of their professional practices. However, this is unlikely to be granted presently given the government imperative to cut costs so we believe that the decision to cut session numbers for the specialist clinical psychologist Medicare items should be reversed immediately.

(c) The extra pressure placed upon clinical psychologists to deliver an intervention in 10 sessions runs the risk of diluting the treatment integrity of these 10 sessions as clinician's try to "fit everything" in an impossible time-frame for those with severe or complex clinical psychological issues.

(d) The decision to reduce sessions from 18 to 10 us based upon a Medicare evaluation with significant methodological flaws which diminishes the credibility of the study. It has been reported that the study did not meet fundamental standards of research design (it did not identify the nature, diagnosis or complexity of the clients seen by psychologists by type of psychologist; it did not identify the nature or type of psychological intervention actually provided; it did not factor in or out medication use by the client; it did not factor in or out therapy adherence indicators; it did not have a valid criterion measure actually related to a range of diagnoses or complexity in order to assess pre and post intervention condition of clients; it did not undertake follow-up assessment of clients, which is often the point at which the relative strength of any competent treatment becomes manifest; it did not determine relapse rates by type of psychologist; it was a self-selected sample of psychologists who self-selected their clients and clinically administered the research questions in session; it was not subjected to peer review); and what is needed is a well-designed prospective study aimed clearly at answering specific questions in accordance with principles of psychological research.

(2) The current two-tier Medicare Funding for Psychologists. Relating to this second matter, I understand that there has been lobbying of the Government to abolish the two-tiered Medicare funding for psychologists (currently Clinical Psychologists are rebated by Medicare at a higher-rate than General Psychologists). I find this curious. Medicare is a body aimed at assisting those with clinical mental health issues, and not *all* psychologists are trained to do this (e.g., an Organisation Psychologist is not trained to treat Clinical psychological illness, and vice versa).

Regarding our specialisation, Clinical Psychology requires a minimum of eight years' training and is the only profession, apart from Psychiatry, whose entire accredited and integrated postgraduate training is specifically in the field of lifespan and advanced evidence-based and scientifically-informed psychopathology, assessment, diagnosis, case formulation, psychotherapy, psychopharmacology, clinical evaluation and research across the full range of severity and complexity. We are well represented in high proportion amongst the innovators of

evidence-based therapies, NH&MRC Panels, other mental health research bodies and within mental health clinical leadership positions.

Clinical Psychology is one of nine equal specialisations within Psychology. These areas of specialisation are internationally recognised, enshrined within Australian legislation, and are the basis for all industrial awards. They have been recognised since Western Australia commenced its Specialist Title Registration in 1965, and it is the West Australian model which formed the basis for the 2010 National Registration and Accreditation Scheme recognition of specialised Areas of Endorsement.

All specialisations require a minimum of eight years training including a further ACPAC accredited postgraduate training in the specialisation leading to an advanced body of psychological competency in that field. As is the case with Clinical Psychology currently, each area of specialisation deserves a specialist rebate with its own item number relating to that which is the specialist domain of that area of psychology (e.g., for clinical neuropsychology - neuroanatomy, neuropsychological disorders/assessment rehabilitation, etc; for health - clinical health psychology, and health promotion; forensic - forensic mental health, etc). Specialist items for the other specialisations of psychology may mean that clinical psychologists might not qualify for any of those second tier items pertaining to other specialisations; however, we deeply respect specialisations within psychology and believe that our members would seek to undertake further training in those fields should they wish to seek to demonstrate that they have attained those other advanced specialised competencies that are not part of clinical psychology.

Such proposed changes to Medicare Rebated sessions, and any disregard of my specialist training qualification as a specialist Clinical Psychologist, would invariably create the closure of my private practice which is located in a very under-resourced, low socio-economic suburb in the Western suburbs. Whilst new investments in mental health care are important and are to be applauded, they should not be at the detriment of existing mental health programs.

Senator, I urge you to reject these proposals immediately and instead maintain the current amount of treatment sessions available with a Clinical Psychologist under the *Better Access to Mental Health Care Initiative* to be 12, with an additional 6 sessions for 'exceptional circumstances'. I also urge you to retain the current two-tiered system of Medicare rebates for psychologists, which rightfully acknowledges and respects the additional, specialist training of Clinical Psychologists in assessing and treating mental health issues (an important function of Medicare).

I trust that my feedback will be given due consideration.

Yours sincerely,