

**SUMMISSION TO : SENATE COMMUNITY AFFAIRS INQUIRY INTO  
COMMONWEALTH FUNDING AND ADMINISTRATION OF MENTAL HEALTH  
SERVICES ,25 July 2011**

Mental Health Consumers, Clinical Psychologists and Psychologists have welcomed the introduction of Medicare's Better Access treatment services to address the significant mental health needs and treatment for a significant number of Australians.

Depending on one's statistical reference point, an estimated 23.3% of Australian's meet criteria for a 12 month prevalence of ICD-10 disorders, the most common being the anxiety and depressive disorders, then personality disorder and more serious forms of psychiatric illness.

The new scheme has been demonstrated through a recent study conducted with the Australian Psychological Society (APS) and Medicare to have made tremendous benefits to the overall mental health outcomes of those who have received the service, regardless of one's socioeconomic status and level of psychological distress and/or impairment. Acknowledging the limitations of this study in terms of its methodology and measures of treatment outcome, the results are consistent with similar studies evaluating the efficacy of these programs overseas (eg., USA, Finland). Anecdotal evidence from peers, clients and my own private practice also supports this. This is despite the view however, of a small but powerful number of protagonists who promote media images that the services do nothing more than treat the worried well, and the educated members of society who know how to access the scheme. If these individuals had the facts, quite clearly their misguided statements which they happily provide to the media and the SPAM boxes of psychologists would be seriously drawn into question by an informed Australian public.

I welcomed the government's evaluation of the efficacy of the Better Access scheme for those with mental health treatment needs, and am always embracing of ways that we, as clinical psychologists, can provide better health care, know our populations and review what is most effective and cost efficient. However, I have three significant concerns about the proposed

changes in the 2011-2012 budget that directly impact our client groups and fundamentally the mental health service delivery to the 23.3% of Australians per year. These are :

1. The impact of changes to the number of allied mental health treatment services for patients with mild-moderate mental illness under the Medicare Benefits Schedule
2. Services available for people with severe mental illness and the coordination of those services, and
3. The two tiered Medicare rebate system for psychologists, notably the claim that “The Senate Community Affairs Committee has concluded that there are no grounds for the two-tiered Medicare rebate system for psychologists and recommends a single lower rate for all psychologists including clinical psychologists...”

I will the issues once by one.

**1. First, the impact of changes to the number of allied mental health treatment services for patients with mild-moderate mental illness under the Medicare Benefits Schedule**

The recent study completed by the APS and Medicare was a useful, albeit a simplistic evaluation to demonstrate that clients with mental health problems are significantly better off after treatment, and often this is after 6 sessions, sometimes 12, and on lesser occasions, 18. This is in line with average utility internationally of clinical psychology treatment services, although the number does not always represent level of severity of presenting issues. Much has to do with diagnosis, formulation of comorbidity and the structure of treatment.

In fact, there are several meta-analytical studies indicating that 50% of people with mental health disorders are much improved by 10 sessions of evidence based therapies, 75% by 20 sessions, and that a further 20 sessions (approximately 40 in total) may be required for that more tail-end of the 25% group, often showing signs of severe personality disorder and severe mental illness by that latter stage of treatment. Reflecting on these statistics indeed

informs us that Australian Clinical Psychologists have done tremendously well to achieve the outcomes they did upon recent review.

I have concerns however with the number of sessions being now capped at 10, with no negotiation allowed for the additional 6 (maximum of 18) under the current scheme. Administratively and clinically it has worked so well in my clinical practice, and that of many others. It allowed the flexibility to see individuals under one stream, that did not discriminate based on severity of illness or one's socioeconomic advantage nor disadvantage. It allowed for ease of providing efficient services timely, without making discriminations on whether a client fits within one group or another, and allowed for autonomy to simply bulk-bill those who were financially unable to pay the scheduled fee (eg., pensioners). No client was ever disadvantaged by access services under this proactive scheme. The 12-18 sessions for those most in need were normally allocated for those with co-morbid, complex and long-term mental health problems, and I found that the continuity of care provided allowed for adequate address of the majority of immediate needs for those most vulnerable. The current framework did not discriminate against eligibility for service based on symptom severity.

Furthermore, I found clients who have often had long-standing mental health problems, and who may or may not have been known to community mental health and hospital services, were very appreciative of the unconditional service that there were now provided through Medicare, utilised their sessions well and often managed their own plan constructively to make most use out of the allocated sessions. The capping of these sessions may be appropriate for the 50% who respond in this time-frame, but is not for those who don't.

It is my proposition that the current 6+6 model should remain, with an allowance for extra 6 in extraordinary circumstances where it is required. The current model works well, why break it. There are a host of new problems that will develop from the proposed fracturing of services with the new guidelines. These are referred to above.

## **2. Second, services available for people with severe mental illness and the coordination of those services, and**

I fully support the multiple levels of intervention that may be required for complex cases and in this way, offering some services to those with severe mental illness or early intervention for those at high risk (eg., through GP Super Clinics and HeadSpace). However, the attempt to introduce new schemes and refund old Ones (eg., ATAPS) to address severe and chronic mental health care conditions chops and slices a population group that does not allow adequately for the continuity of care in most individuals, and creates what can be an arbitrary classification of people's mental health problems as either mild, moderate, severe or extremely severe. This is not clinically always a heuristic classification system, and as clinical psychologists are much aware, poses many dilemmas in terms of how these constructs are measured, who makes the classification and whether it necessarily makes a difference in outcome.

In the addition to the dilemmas of deciding "who goes where for what sort and severity of illness", there is the significant risk of duplicating unnecessary services across various schemes. This includes putting more money in to the hands of administrations that need to create or build on current schemes by adding the costs of additional building and staff support, a cost that is currently contained by Clinical Psychologists and others' treatment services and its infrastructure. This is likely to lead to employing less experienced clinicians on reduced salaries as attempts are made to manage costs.

I support the need for extending mental health schemes, but ensuring there is an economisation of the process that prevents duplication of service delivery and prevents clients falling through administrative cracks in service systems, based on how severe the individual's problems are deemed to be. This happened over the last 20-30 years between community mental health, aged and disability services, and other agencies who had to juggle whether to accept individuals as entitled to one service or another, and forcing some agencies to establish sometimes debatable criteria for what is considered mild, moderate, severe or very severe condition – often an arbitrary assessment.

I propose the above issues are debated in reviewing the costs and benefits of re-allocating funds from the Better Outcome Initiative for mental health services in Australia.

**3. Third, the two tiered Medicare rebate system for psychologists, notably the claim that “The Senate Community Affairs Committee has concluded that there are no grounds for the two-tiered Medicare rebate system for psychologists and recommends a single lower rate for all psychologists including clinical psychologists...”**

The Senate Community Affairs Committee conclusion that there are no grounds for the two tiered Medicare system for psychologists and clinical psychologists is unfounded. If the committee deducted this reasoning from the APS and Medicare recent study, it was incorrect to do so. The measures used would not have sensitively tapped into the psychological interventions that are well established to be more superior in clinical psychology, and those who undergo the training for it.

Clinical Psychologists are a unique subgroup of Psychologists in Australia, constituting 15-20% of the overall group. Their level of skills, qualifications and extensiveness of training surpasses that of a four year trained intern who gets 2 years supervised experience before being able to register as a psychologist in Australia. Clinical Psychologists require a minimum of 8 years intensified training, in particular in the assessment and treatment of the full range of mental health issues that present across the lifespan. Only a small percentage of psychologists are eligible to join clinical programs, normally being a first class honours degree from a 4<sup>th</sup> Year Psychology Honours, or a comparably high grade with substantial experience. The bulk of registered psychologists, and definitely the new 4+2 interns currently within the registration schemes do not meet these criteria and rigour of training, and yet after registration, can access a Medicare Provider Service Number and begin to immediately offer treatment services to members of the public in their own private settings.

Generalist and Clinical Psychologists are by definition different occupational groups, with clinical psychologists having expertise unique to their training and competences in managing people with mild to very severe mental health problems. As a parallel, GPs do not compare themselves to Psychiatrists because they have completed a 20 week course in cognitive behavioural therapy, and it is for this reason, Medicare has rightfully so, maintained a two tiered system of Medicare rebates for the services being provided by two groups, the generalists and the specialists.

Fundamentally, this is an issue about standards and acknowledging the international standards already set down overseas in terms of providing levels of care to those with mental health problems. In the UK and the USA, generalist psychology graduates are used for basic assessment and 'technical' processes, and some level 2 interventions such as basic counselling. However, the bulk of work assessment and treatment planning wise, in particular for complex cases, is the field of clinical psychology, covering Level 2 and Level 3 interventions for complex cases requiring unique case conceptualisation and individual treatment planning.

Clinical Psychologists have always been recognised as a specialty group with advanced diagnostic and assessment skills, and it was not until the Medicare two-tiered system was introduced that some (a minority group) of 4 year trained clinicians begin to assert the perceived inequity of it all.

Fundamentally, in my eyes, the issue for them comes down to the dollar. I have had a thriving private practice since 1995 that predated the Medicare system and I have never come across any disputes about differentials in level of specialty until the Medicare system was introduced. It was also my understanding that Medicare's Better Access Initiative for mental health problems was initially just to rebate clinical psychologists, however, the Australian Psychological Society lobbied for inclusion of generalists, as the latter group constitutes 4/5 of its membership.

I supervise many 4 year trained psychologists who work as Medicare service providers. Acknowledging they all have a learning curve and level of

competence, I find myself in promoting their level of development, emphasising the importance of working within ones' level of expertise and being reminded of the higher standards on average achieved by those with an 8 year specialty training in clinical psychology.

Thus, I request that the Inquiry strongly support the maintenance of the current two-tiered system of rebate as an effort to acknowledge the specialty in the discipline of clinical psychology and fundamentally ensure that ongoing high quality of care is being provided by this group to Australians with mental health problems. My understanding is that 50% of the public so far choose to see a clinical psychologist rather than a generalist psychologist, and it is my experience that these were the trends in referrals predating the introduction of the Medicare rebate scheme.

I strongly urge the Inquiry to address each of my main concerns and adhere to the recommendations to maintain the standard of mental health care that is being provided to the Australian public by Clinical Psychologists.

Yours Sincerely

Name Withheld