5 August 2011

Senate Community Affairs Committees
The Senate
Parliament of Australia, Canberra

I wish to make a submission to the Committees' inquiry into the Government's funding and administration of mental health services in Australia, with particular reference to the changes to the Better Access Initiative in the 2010 budget, including 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; and to the 'two-tiered' Medicare rebate system for psychologists, including the Specialist Endorsement aspect of the national registration of psychologists. I believe I have experience relevant to these issues.

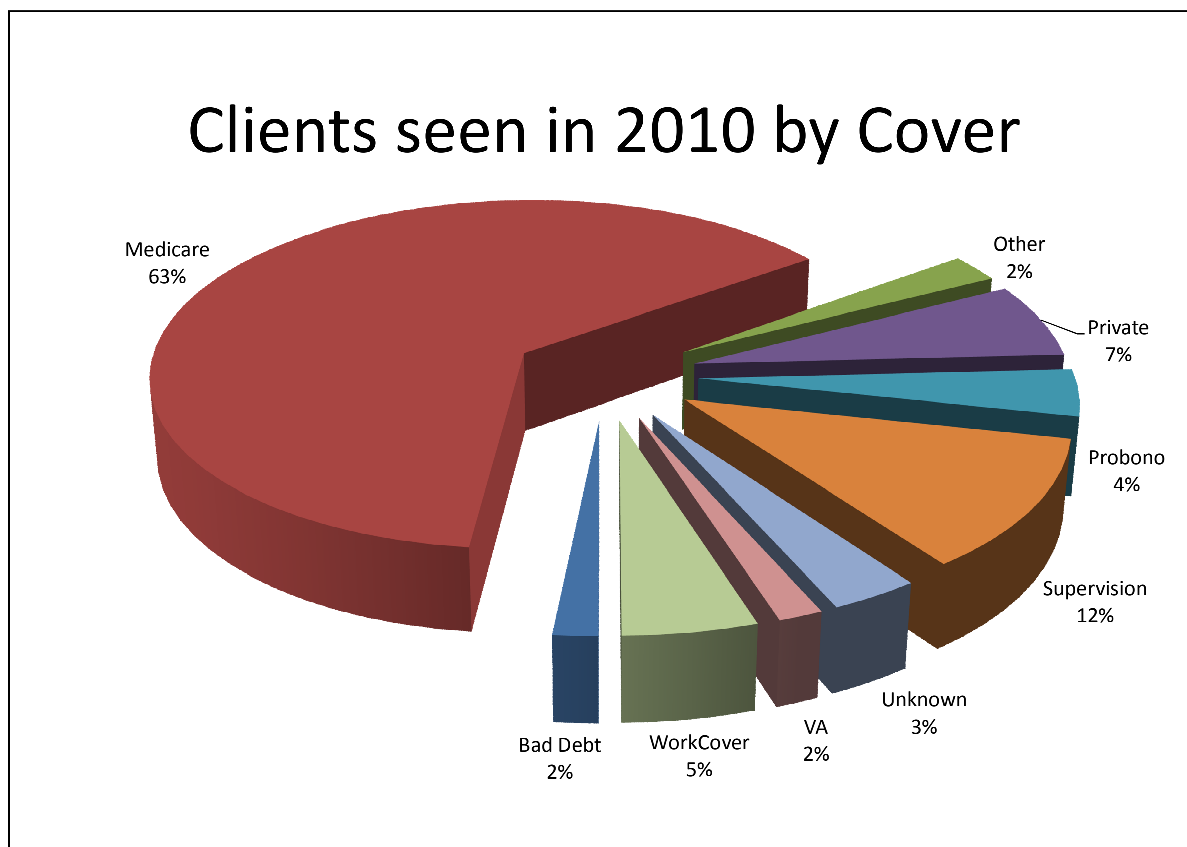
I am a registered psychologist in Australia with endorsement to practice in the area of Clinical Psychology. I was first registered in Queensland in 1981. Prior to that I worked in New Zealand as an Assistant Psychologist for one year, in 1980. This was an internship position as part of the Diploma in Clinical Psychology Training program. I have a Bachelor of Arts double majored in Psychology from Macquarie University completed in 1977. I have a Master of Arts degree in Psychology with second class (Division I) honours from the University of Canterbury completed in 1978. I have a Diploma in Clinical Psychology from the University of Canterbury awarded in 1981. The Diploma in Clinical Psychology is the equivalent of an Australian Masters degree in Clinical Psychology. I have a doctorate of Philosophy from the University of Queensland awarded in 1997. My PhD research was on psychological and biological changes in persons recovering from depression whilst receiving cognitive therapy. I worked at Sunnyside Psychiatric Hospital in Christchurch New Zealand in acute inpatient psychiatry, rehabilitation psychiatry and intellectual disability. I worked for Queensland Health from 1981 till 1994. During this time I worked in intellectual disability (5 yrs) geriatric psychiatry (1 yr), community psychiatry (5 yrs), acute inpatient psychiatry (2yrs), and as Psychologist in Charge at the major inpatient psychiatric hospital in Brisbane (2 yrs). From 1993 till 2008 I held a half time position as a lecturer in Clinical Psychology at Griffith University, Brisbane, Australia. In my time at Griffith University I taught in courses on counselling and abnormal psychology in the undergraduate program, and in courses on Cognitive Behaviour Therapy (CBT), psychopathology, assessment, and professional practice in the post-graduate clinical psychology training program. I am

arguably one of the most experienced professional supervisors in psychology in current practice in Queensland. I estimate I have supervised over 200 other psychologists over the course of my 30 year career. I have had a half-time adult clinical psychology private practice since 1998, and in July 2008 extended that to full-time. I have written two editions of "Cognitive Therapy in Groups: Guidelines and resources for practice", published by John Wiley and Sons, Chichester in 1999 and 2007.

I am sure that many psychologists will be writing submissions based on reviews of the literature and the structural aspects of training of psychologists. I was one of the first people with specialist training in Clinical psychology to work in Queensland, have been in practice for 30years in both government and independent practice settings, and have experienced the Better Access initiative since it commenced. I therefore believe I have observations relevant to the issues that can put a more human face to the structural and literature-based comments.

My Practice in 2010

It can be seen from my brief CV above that I have worked in Government inpatient and outpatient adult mental health, in addition to independent practice. I have practiced in both affluent city areas and in relatively socially deprived regional areas. My policy has been to bulk-bill people who are retired, on pensions, are full-time students, or who are in low-paid employment. Figure 1 shows the breakdown of clients seen in 2010, the index year I shall use for this exercise.



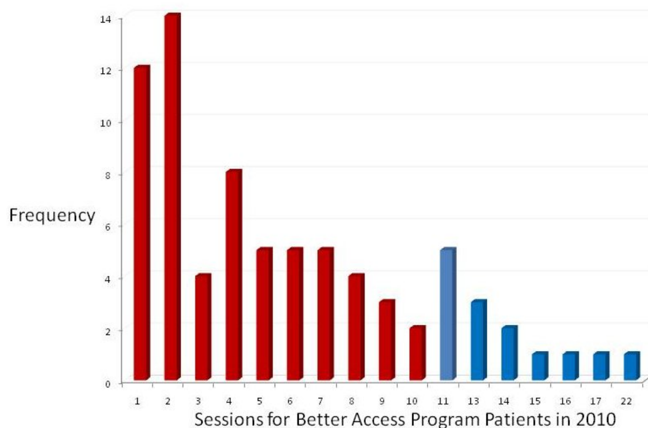
The group consists of 120 people, some of which I had seen in previous years and some of which I continued to see in 2011. The pie chart shows the breakdown according to cover. It can be seen the majority of clients, (63%, or 76 people) I saw in that time were referred through the Better Access program. The other 37% was made up of supervision of other professionals (12%), people paying for sessions out of their own pocket or through private health insurance (7%), and a similar number paid for by other third parties such as WorkCover or Veteran's Affairs. This 76 people will be the basis of the discussion in the sections that follow.

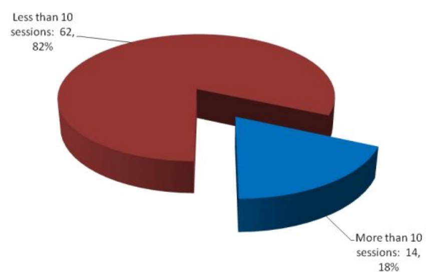
The reduction in Psychology sessions available for individuals in a Calendar Year under budget changes in the 2010 budget.

The 2010 budget involved a much touted increase in funding of areas associated with mental health but reduced the Psychology sessions available for individuals in a calendar year under the Better Access scheme from 6+6(+6 under special circumstances), thus effectively reducing the number of sessions available to the most vulnerable people, i.e. those with 'exceptional circumstances' from 18–10, almost a 50% reduction. It is ironic that a welfare initiative initiated by a Liberal Government in Australia, which had proved popular and effective, was effectively reduced by almost 50% by an ALP Government.

The graph shows the frequency of number of sessions in 2010 of the 76 clients seen under the Better Access program in my practice in 2010. It can be seen that 14 Better Access clients had more than 10 sessions in 2010. The impact of the reduction in available sessions can be addressed by considering the details of these cases and the benefit versus costs that might have ensued if these people had only had 10 sessions as is proposed under the budgetary changes.

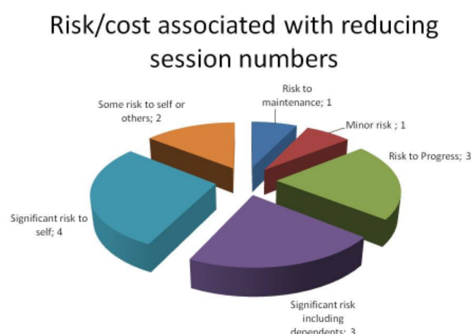
The graph shows the number of sessions per client. Only 14 clients had more than 10 sessions. One client had 22 sessions of which the four additional to those provided under the Better Access program was provided by me at $10 per session. There were 48 sessions





paid on this group that would not be paid under the new rules, costing Medicare, and ultimately the Government and the Australian Taxpayer $5647.20 at the Clinical Psychology refund in 2010 of $117.65 for each 50-60 minute session. Let us now address the potential cost of those sessions in human terms. I have considered those clients and developed the following table, assigning a level of risk/potential human cost to each client.

Maintenance	1
Minor	1
Progress	3
Significant risk to self and	3
Significant risk to self	4
Moderate risk to self and/or others	2



'Maintenance' means that the extra sessions were for maintenance of gains. This client had three extra sessions. He was (and continues to be) a severely depressed man, but continued to work productively over the period. It is possible he would not have continued to be productive and to support his family, which includes a child with special needs, and the community, since he is a community volunteer, during the period. The cost to Medicare was $352.95

'Minor' refers to a case in which a man who had largely recovered from depression but with multiple dependents, who attended for his eleventh session, at a cost of $117.65, to ensure gains made in therapy were maintained. The extra session probably made no difference.

'Progress' refers to three clients who between them used 11 sessions in excess of ten, costing $1,294.15. They all made progress over that period, and although there was probably no risk involved to themselves or others in terms of even minor harm it is possible that the progress towards mental health and productivity would not have been made.

I have listed two people as having 'moderate' risk/cost. One of these was a man who has been imprisoned for physical assault on his partner. It is possible he would have made another assault on her and/or returned to prison had he not been in therapy. The other is a woman who is a carer for a grandchild who is the son of a recovering heroin addict. It is probable that if my client was not receiving therapy, and therefore became less able to care for her grandchild and support her daughter, that there would be a cascading effect in which her daughter would have recommenced using heroin and the grandchild would have been considered for child protection intervention. The cost to Medicare was four sessions at $117.65= 470.60 for these two people. The potential costs of incarceration in one case, and a child protection investigation would have been vastly in excess of that amount, in addition to the obvious human misery that would have ensued.

Four people are listed as being at ‘significant risk’ to themselves. Three of these are under 18. Two have made known self-harm attempts and have only survived by random chance. The other young person is a complicated case in which the depression is of unclear origin and therefore associated with unpredictable behaviour. Suicidal behaviour was quite possible in this case also. The fourth person in this group is chronically suicidal and extremely marginal in his functioning. Now in his mid 30s, although highly intelligent, he has never worked. In my opinion he is a person suffering from severe Post Traumatic Stress Disorder as a result of institutional abuse and failure to intervene effectively by statutory child protection authorities. It is probable that therapy has reduced the suicidal behaviour of these clients to a level that they have been unsuccessful as yet. The cost to Medicare in 2010 of the sessions in excess of ten for these four people was 19 * 117.65= $2,235.35.

I have listed three cases as involving significant risk to the client and associated dependents. The clients are all at risk of suicide and one is additionally at risk of perpetrating violence and incarceration. There is also risk of abandonment of the dependents or incarceration of the client. For two of these there are no closely related alternate carers that I would assess as adequate. The third is a heroin user and reformed criminal, with multiple incarcerations, and who almost certainly has been prevented from abandoning his family and/or going to gaol by therapy. The cost to Medicare of sessions in excess of ten was 10*117.65= $1,176.50.

It is of course impossible to be sure of the outcomes of reducing services to these people, and many of the people I have described might have survived if they had not had the sessions in excess of ten that they did have, Nevertheless it is clear from the details provided that this is not “Middle-class welfare”. The 6+6(=6 in ‘special circumstances’) make up of the unmodified better access has allowed me, in conjunction with GPs, to provide a service to these individuals which has been able to keep them safe over a twelve month period. Of course all the risky behaviours predicted would not have occurred, but in my opinion it is highly probable that without therapy at least one of the predictions I have made for the nine more at-risk clients would have occurred, with a much more substantial cost than $5,600, and the potential to have a significantly negative effect on at least three lives in each case. If my sample is representative, then this trend could potentially be extrapolated to 3 people damaged for every Full-time equivalent psychologist involved in the Better Access Program. I respectfully ask that the Committee consider that cost in the context of the $5,600 that would have been saved.

Specialist Endorsement and the Two Tier Structure in publicly funded psychology services to individuals.

At present there is a “Two-tier” structure in psychology in Australia. This is supported by the Medical Benefits Schedule (MBS) and the Allied Health Practitioners Registration Board (AHPRA). The MBS allows for “Focussed Psychological Services” and “Clinical Psychology

Services". These services are delivered under the auspices of the "Better Access to Mental Health" program. Focussed psychological services can be delivered by registered psychologists with approved four-year degrees, and by some other appropriately qualified professionals, such as medical general practitioners who have undergone special training.

The two-tier system in the National Allied Health Registration system is by "endorsement" as qualified to practice in certain areas, including clinical psychology. Evaluating a psychologist as being able to provide clinical psychology services is done for the MBS, and for AHPRA, by the Australian Psychological Society (APS), and broadly equates in both cases with eligibility for membership of the APS College of Clinical Psychologists. This body has developed and revised its entry criteria over many years, with reference to international standards. In general, eligibility for the College involves a minimum of completion of a two year full-time post-graduate course of study in an APS approved clinical psychology training program, usually associated with the award of a degree which might be a Master's degree in Clinical Psychology, a professional doctorate in psychology, or a PhD in Clinical Psychology. Clinical psychology services incur a higher rebate under the MBS than do Focussed Psychological Services.

There is a clear difference between the two groups of psychologists. One group, those eligible for endorsement as clinical psychologists, has received a minimum of two years additional university based training in the speciality, or has demonstrated equivalent skills and knowledge by virtue of overseas qualifications or by examination or evaluation, or was grandparented in to Clinical College by application in the early 1980s. The other group has had some supervised experience, (different in the different states) after completion of their four year degree to fulfil requirements for full registration. A glance at the requirements for both (and I have been involved in supervising psychologists at both levels in Queensland) will show that the standards are quite different in scope and requirements. For this reason there is no question as to whether there is a difference in both training and requirements for completion of the processes, i.e. award of the degree or full registration, but the question is whether that difference justifies the two tiers of Medicare payment and the specialist endorsements.

I wish to comment on this issue from three perspectives. First, from an analysis of the issues involved, second from a review of my own experience, and third from an analysis of my own practice.

Issues in a two tiered system of payment/ and recognition of specialist qualifications

Training in clinical psychology is an internationally recognised core set of skills, knowledge, and practice. It involves comprehensive training in the theory and application of the main psychological theories of psychopathology in the domains of assessment, diagnosis, formulation and therapy. It is different from the training received by people who do not undertake a university based clinical psychology training course in: the extensiveness and

depth of the knowledge base, the comprehensiveness of the range of theories, the range of applications, and the subtlety of diagnosis covered in the experience. Major aspects of clinical psychology training are specific practical training in the main therapy techniques, extensive and intensive training in case formulation, and intensive coaching in the interpersonal processes of therapy. Other skills are also addressed such as program design and evaluation, but they are not relevant to the present issues.

It would be expected that people with this kind of training would be better equipped to deal with complex cases by virtue of increased ability to do individualised treatments based on sophisticated formulations, and be able to deliver therapy with a higher level of technical and interpersonal skill. It is therefore logical that people with specialised clinical psychology training would be substantially better at dealing with difficult and complex cases, both analytically and interpersonally, but perhaps only a little better at treating routine cases. This is not an unusual situation in many fields of endeavour, including medicine, catering, and live sound engineering, just to name some fields I am familiar with. In many of these fields a person with more basic training can handle routine tasks, but a specialist paediatrician, a qualified chef, and a trained sound engineer would be generally expected to be able to perform more complex tasks in the respective domains than their counterparts with less formal training and lower levels of recognised qualifications.

It is normal in Australian society to financially reward people with more advanced formal qualifications in various domains. There are also a number of other reasons why there would be financial recognition of the extra training, including the following: greater degree of effectiveness, more ability to take responsibility, greater degree of efficiency, and for the purpose of attracting or retaining desirable workers in a particular sector. Several of these reasons involve nebulous constructs such as efficiency and effectiveness. These constructs are notoriously difficult to evaluate in the mental health area for the following reasons:

- The constructs are difficult to define. For example, determining what ‘improvement’ and ‘recovery’ are in the mental health domain, and determining the time scale over which the construct is assessed.
- The constructs are difficult to measure. There are few measures of mental health functioning that are relevant to the general population. Many measures of symptomatic recovery are controversial, or applicable only to a narrow range of people.
- There are ethical problems in comparing treatments, in this case treatment by more qualified and less qualified psychologists. It is unethical to have distressed people receiving treatment that might be thought to be less effective.
- There are technical problems in drawing statistical conclusions because of the above difficulties, and because the amount of variance available to be explained in a comparison study of treatment outcome of therapist factors is very small, probably less than ten percent, meaning that a fairly large study would be necessary to have sufficient power to produce a result.

Of course as a research based discipline it behoves clinical psychology to address whether or not the extra training does make for more effective, efficacious, or efficient treatment, especially in the complex and moderately distressed domain of mental health, but because of the above problems it is highly unlikely that there will be any definitive answers to these questions in the next few years.

This is not to say that people who have not done the university based training cannot obtain the skills themselves or are necessarily incompetent. It just means that such people cannot necessarily be *expected* to have the standard core specialist skills and knowledge of clinical psychology. This because they have not undergone a program of training that is subject to quality controls and international standards, and that involves rigorous evaluation of those skills and knowledge.

Finally, even though in Queensland where I have worked there has been no formal recognition of specialist clinical psychology qualifications in pay scales in the government mental health area for most of the last 30 years, it is my experience that psychologists with these qualifications have secured higher paid positions by competitive application, resulting in a de facto recognition of the desirability of the qualification in the sector. If it is desired to have the more highly qualified psychologists servicing people in the better access initiative, then it makes sense that there is a competitive payment for them.

If it is acknowledged that there is a real difference in the level of skills, knowledge and application acquired in training between specialist trained clinical psychologists and those who have not competed that training, there are three possible ways of dealing with this:

- Both are paid the same
- Payment is according to qualification of the provider
- Payment is according to the complexity of the case, or level of interpersonal skill required by the therapist

There are pro and cons for all of these. In the first case, if there really is difference in expertise, then there is the possibility that more complex cases will be treated with overly simplistic or indelicate approaches by less trained psychologists, since equal payment could mean that referring agents do not discriminate between clinically trained and non-clinically trained psychologists. Furthermore if the rate paid to clinical psychologists is not competitive the more expert psychologists will be less likely to work in the better access program, or will charge a bigger gap, thereby restricting services to more affluent clients.

The second case is the current situation. It has the advantage that it is simple and easy to audit. A person either has the qualification or not. The major problem is that the clinical psychologist is being paid for doing routine work that could be done more cheaply by a less trained psychologist.

The third case makes practical sense in the execution, but not in the referral and charging/auditing process. There are two possible ways it could be organised. Referring general practitioners could refer complex clients to clinical psychologists and routine clients to less trained psychologists. This would place a greater burden of assessment and decision making on GPs than there is currently (although I believe this may be happening to some degree currently). Moreover, many cases look routine until after a number of sessions. Alternately the decision would be made by the psychologist to treat routine cases or refer on and the clinical psychologist to charge different item numbers based on the complexity of the case. Clearly, auditing the latter would be extremely difficult. None of these three alternatives is clearly optimal.

Comments on the 'Two-tier system' or the validity of the recognition of the difference between Clinical and non-clinical psychologists from my own experience

I have been working as a psychologist in Australia for thirty years. I have experienced the work of other psychologists as a professional supervisor, a lecturer in an accredited Clinical Psychology training program, as an evaluator in the Queensland Supervisor Training and Accreditation Program, and as a manager of a large (by Australian standards) psychology service. I believe I have become intimately aware of the work of about 300 other psychologists in the following contexts:

- General professional supervision of both 4 year trained and 6 year trained psychologists
- Supervision of people with 4-year degrees fulfilling the requirements for full registration
- Supervision in the field and within universities of people in the process of completing the six-year plus professional training programs
- Recruitment and selection of psychologists for both entry level and senior psychology positions in both major psychiatric hospital and community positions
- Selection of people for an approved clinical psychology training program
- Supervision of psychologists who have completed the academic component of eligibility for Clinical College membership

My observation is that with only a handful of exceptions, about 1%, there is *always* a clear difference in the functioning of four-year trained psychologists and those who are even part-way through their postgraduate professional training. This difference is apparent in their general work, their written work, their functioning in supervision sessions, their performance at employment selection interviews, and their performance in video or audio recorded sessions. Not counting the very few exceptional four-year trained psychologists noted above, the best of the four-year trained psychologists may be very good at functioning in the area that they work in, but from my observation the six-year-plus trained psychologists are generally better in the following ways:

- They have a better knowledge of psychological theory both in extent and depth

- They are better able to apply their psychological theory to novel situations or position requirements that go beyond basic provision of one-to-one services, such as managing organisational issues, training staff, and designing programs
- They are more creative in their clinical work
- They have a more subtle and comprehensive understanding of professional ethics
- Their therapy process skills are generally better, and they have a better understanding of therapy process
- Their therapy technical skills are better, such as being better able to apply subtle aspects of cognitive therapy or the more technical aspects of operant conditioning
- They have a much better understanding of what can go wrong in therapy and are alert for such factors
- They are more able to design a formulation based treatment program
- They have a better knowledge of empirically validated psychological treatments

None of this is surprising since it is exactly what is taught in the post-graduate programs. My comment though is that the teaching *does* make a difference, people who undertake the postgraduate training programs *do* come out with the above enhanced skills, knowledge and abilities. Therefore I strongly support the recognition of the completion of such studies in some ways, including such things as specialist endorsement or registration, and access to higher pay-points on entry to public sector employment. I have long been an advocate of both the above, and have not seen any evidence that such a position is misguided, though I would support alternate routes to the university training approach, so long as the outcome standard is equivalent to the current university course based standard. I therefore strongly support the financial recognition of the extra training in the Better Access initiative and any similar programs, but also see it as desirable to tie that financial recognition to some aspect of increased complexity and subtlety of the work required.

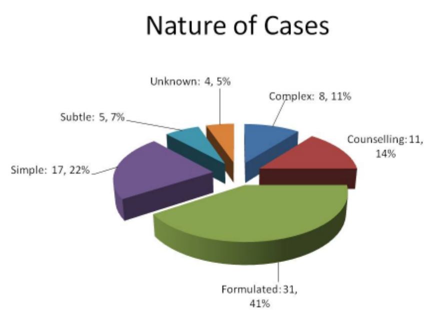
Review of my own case-load: Complexity and subtlty required

To address the issue of the level of complexity of psychological problems found in clients referred under the Better Access program I reviewed my own case load of clients seen in 2010. In 2010 I was primarily practicing in a relative affluent metropolitan area (Brisbane), but also had a practice in a regional centre (Ipswich). I have 44 available patient sessions in a fortnight, six of which are at the regional centre.

The graph and table below shows the breakdown of cases according to the following criteria:

Label	Description	Number	Percent
Complex	People requiring both complex formulations of the predisposing, precipitating and perpetuating factors and subtle management using advanced interpersonal skills.	8	11
Counselling	People requiring use of counselling skills for a range of low intensity mental health problems usually interpersonal in origin	11	14
Formulated	People requiring a formulations of the predisposing, precipitating and perpetuating factors and an associated relatively complex	31	42

	individualised treatment plan		
Simple	People with mild to moderate emotional distress but with relatively routine presentations that were treatable with routine treatment approaches.	17	22
Subtle	People who require subtle management using advanced interpersonal skills for reasons of personality disturbance or cultural or sub-cultural factors	5	7
Unknown	People whose level of complexity was not verifiable when preparing this document	4	5



It can be seen that, consistent with the above argument, in my opinion at least 57% of my client load requires clinical psychology skills and knowledge. It can also be concluded that for 36% I may be providing little more quality of service than a less qualified psychologist would. It is uncertain how representative my practice is, unfortunately. Since I am a well known Clinical Psychologist in Brisbane, it is likely that I would be referred the most complex cases. Furthermore I tend to accept the most complex cases because there are few psychologists available with more qualifications and experience. Thus, it is likely that if anything, my case-load includes more complex cases than others might. Thus, although I favour a system that would recognise the differences in complexity of cases and provide payment accordingly, the benefits of introducing such a system would need to considered in the context of the relatively small potential gain (probably less than $10,000 per clinical psychologist) and the complexity of introducing such a system.

I therefore support the retention of the 6+6(+6 under exceptional circumstances) allocation of sessions per calendar year under the better access program, the recognition of the additional training of clinical psychologists by endorsement or some other means, and the two-tiered payment system for psychologists as it currently exists, with some education of GPs to refer the more complex and difficult cases to Clinical Psychologists. The current system has been shown to work, and in my opinion is cost effective and minimal. I believe that I have demonstrated that modifications of either factor reviewed would probably have negative human effects in excess of any financial gains that would be made.

I hope the above is of assistance to the Committees. More information about me can be found at http://drmichaelfree.wordpress.com/

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