

Senate Community Affairs Reference Committee inquiry into Commonwealth Funding and Administration of Mental Health Services

Submission by

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Preamble

As this is a submission presented by an individual Clinical Psychologist practitioner, I shall restrict my comments to the areas of my expertise.

My areas of expertise

I have worked in the field of mental health as a Psychologist and specialist Clinical Psychologist for 31 years. I am also qualified to practise Social Work and have completed Doctoral studies in Forensic Psychology. I have supervised Psychologists, Clinical Psychologists, Psychiatrists, General Practitioners and Forensic Psychologists. Currently I am president of the Institute of Clinical Psychologists Western Australia (ICP). This Institute represents the interests of Clinical Psychologists in private practice in Western Australia. It has been established for over 30 years.

My private practice spans the mental health and forensic fields. My background in mental health includes 10 years employment in public and outpatient mental health settings. In my private practice, patients that attend for treatment cover the entire socio-economic spectrum and encompass the full range of mental health disorders as I am permitted to treat under the Medicare scheme.

Summary and recommendations.

The following summary is provided in the structure of the Terms of Reference. Reasons for the opinion provided are detailed after the summary.

The rationalisation of Allied Health treatment sessions:

- The reduction of treatment sessions from the current 12 + 6 will seriously disadvantage patients with complex mental health problems by denying this group access to needed Clinical Psychological treatment.*
- It is recommended that available treatment sessions for this group be increased to the equivalence of that recognised as necessary for treatment by a Psychiatrist, that is 50 sessions per year.*
- The current emphasis on focused treatment strategies dictates and limits treatments that are required by mental health patients. It is recommended that the emphasis on focused treatment strategies be removed and instead the emphasis be placed on treatments that are evidenced informed .*
- The administrative requirements with the emphasis on reporting after every 6 sessions and General Practitioner permission for ongoing treatment has shown itself to be rigid, interfere with treatment. It is recommended that reporting should be undertaken similar to that of Psychiatrists, that is after the patient is first assessed and regularly as is dependent upon progress or significant changes.*

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 loss of the two tiered system and reduction of rebates to the equivalence of those provided to 4 year trained Psychologists will result in loss of needed specialised Clinical Psychology services to mental health patients.

- The loss of Clinical Psychology services will eventually lead to failure of treatment and increased costs to the Australian Community.

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;

- Whilst 6 treatment sessions is reasonable for mild mental illness, mild to moderate mental illness can either mask more serious mental illnesses or become serious mental illness if not treated appropriately or if there are underlying complex issues.

- There needs to be a way for Medicare to recognise that patients can transition from mild/moderate illness to more serious mental illness requiring more treatment sessions than the proposed 6 plus 4 sessions.

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

- Though a program known as the Access to Allied Psychological Services has been in operation, no details are available regarding the proposed new program. Without details it is not possible to comment on the adequacy of the new program.

- Funding for the old program and administration of the old program via GP divisions was inadequate. If the funding model is retained in the new system, then it will be a reduction in services that can be provided.

Mental health workforce issues, including:

- (i) The two-tiered Medicare rebate system for Psychologists.
- (ii) Workforce qualifications and training of Psychologists.

- The two tiered system should be retained. If it is removed and rebates are reduced, then, there will be:

- loss of expertise to Australians who suffer mental illness.*
- failure of Australia to follow world's best practice.*
- increased costs to the Australian community.*

- Specialist Clinical Psychologists should be recognised for their training and expertise. They are the leaders in the psychological treatment of mental health patients and provide higher level skills which are not available in 4 year trained Psychologists. This is recognised throughout the Western world.

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.

- Medicare rebates should be available for outside of metropolitan consultations undertaken via the Internet as is the case for Psychiatrists and Nurses.

- A secure Internet network should be established that provides for the confidentiality of patient consultation.

Any other related matter.

- It is recommended that the Standing Committee dismiss statements that 4 year trained Psychologists provide services equivalent to 6 year and more trained Clinical Psychologist.

- It is recommended that the Standing Committee closely examine the motives for such statements as they are in direct conflict with:

- The history of the development of specialised Clinical Psychology services in Australia.*
- The history of the development of specialised Clinical Psychology services in the Western World.*

Detailed reasons for the above opinions and recommendations.

Background

The speciality of Clinical Psychology, apart from Psychiatry, is the only profession, 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.

The introduction of the Medicare scheme provided access to patients who could not afford high quality specialised Clinical Psychology services. The problems patients present with under the scheme range from simple and straight forward to those that are complex and life threatening.

In mental health, simple and straight forward problems, if not treated, can quickly become complex and life threatening. For these straight forward problems the Medicare scheme has proven to be invaluable because treatments can be administered that are focused and short without the additional worry to the patient that they cannot afford treatment. From the experience I have, I believe that the short focused interventions have acted in a preventative manner and fiscally saved the Australian community by stopping the emergence of more serious mental health problems.

Impact of Changes and the adequacy of services provided to people with mental health issues.

The restriction of the current system to 12 sessions with a possible additional 6 sessions under exceptional circumstances has been problematic to those with complex and serious psychological problems. Further reduction of these sessions to 6 sessions with a possible additional 4 sessions will create extreme limitations in the capacity to treat those suffering serious mental problems. I include in this group those with both acute and chronic complex problems. In addition, the administration of the Medicare referral process has shown itself to be a dangerous interference in treatment of these patients. I will address these two problems.

Impact of the inadequate number of sessions both currently and in the proposed changes.

Serious complex mental illnesses can be divided into two types, habilitative and rehabilitative types. In habilitative types, the patient has never developed the skills for psychological survival and needs ongoing support. In most cases it is unlikely that this group will ever fully

function independently. In contrast, the rehabilitative type have suffered serious mental health breakdown and need treatment to re-establish healthy coping and to develop new coping strategies so as to prevent future breakdowns.

Both the habilitative and rehabilitative groups require long term extensive regular, sometimes weekly, treatments. This is well recognised in the field of psychiatry where Medicare provides for weekly treatment.

The current 12 plus additional 6 sessions are inadequate to support and treat these two groups. The proposed 6 plus 4 additional sessions will provide little capacity to treat patients suffering serious complex illnesses as present in the habilitative and rehabilitative groups. It is both these groups that fiscally cost the Australian Community in multiple ways, for example through increased use of medical and social services, failed relationships, imprisonment, inpatient treatment and inability to remain employed.

I recommend that the Medicare scheme for these two groups be increased to reflect the needs of these people, that is to the equivalent of Psychiatry - 50 sessions per year.

Impact of dangerous interference in treatment. This dangerousness comes from two sources, the prescription of treatment via focused intervention strategies and the administrative requirements.

With respect to focused intervention strategies, these strategies are based on the principle of “Ockham’s razor”, that is the hope that simple prescribed treatment strategies will resolve complex mental health problems. The idea that psychology has simple solutions for complex problems was abandoned a long time ago, that is in the 1980's (see Sameroff, 2010 who addresses the history of simple solutions, complexity of human development and the development of psychological problems).

As stated above, for a group of patients with simple straight forward problems, the Ockham’s razor principle in the form of focused intervention strategies works well. However, for complex problems as evident in the habilitative and rehabilitative groups described above, these strategies are inadequate, and if applied, can lead to worsening of mental health. This occurs because the patient develops a sense of hopelessness due to failure to gain from the

focused intervention strategies. This failure occurs because patients do not have the necessary assumed skills required of these models. For the community, the increased costs of this failed treatment can be high. For the patient, the worsening of his/her mental health condition can be as serious as death via suicide.

I recommend the removal of the requirement for focused intervention strategies or any form of prescribed treatment other than that it should be evidenced based.

With respect to administrative requirements, the current administrative requirements that demand ongoing reports to General Practitioners and from General Practitioners and continuous approval from General Practitioners disrupts patient treatment. I have had cases whereby patients who are suicidal and who have not been able to see their General Practitioner for a 6 session review. Without the review, they have not been able to attend treatment because of cost constrictions. The auditing process of Medicare has made it clear that before treatment can continue, the necessary paper work must be completed.

This emphasis on paper work takes no account of the mental state of the patient or his/her needs. I have had situations whereby patients have become suicidal and needed hospitalisation because they have feared not being able to continue their treatment as a direct result of their inability to obtain an urgent appointment with their General Practitioner so as to have the necessary paper work completed.

I recommend that the administrative requirements for review every six sessions be removed and the model applicable to other medical professionals be applied, that is a Psychologist is only required to write to a referring GP when appropriate such as after the initial assessment and following significant changes.

Workforce qualifications and training of Psychologists and the two-tiered rebate structure for Clinical assessment.

In the field of mental health, Psychologists who are 4 year academically trained and those with a minimum of 6 years' academic training treat patients. Over thirty years ago the community of Western Australia concluded that 4 years of academic training was an inadequate preparation for treatment of mental health problems. The then State Mental Health Department ceased employing 4 year trained graduates and via legislation, the

Government created the category of specialist Clinical Psychologist for those considered to have attained the necessary skills and qualifications. This recognition remains world's best practice and is followed in the United States, UK and Europe (Lane and Althaus, 2011 for the European experience and commentary on the necessity and recommendation for the development of clinical skills associated with psychotherapy to be based on Clinical Psychology training. Psychotherapy is a core skill for Clinical Psychologists).

In Western Australia this recognition has continued with private health funds only rebating for services provided by Clinical Psychologists and WorkCover recognising Clinical Psychologists as treatment providers for those suffering mental health problems flowing from work and motor vehicle accidents.

The recognition of the increased skills and responsibilities of Clinical Psychologists in treating mental health problems has been shown via higher rebates under the Medicare scheme and higher remuneration in salaries. This is also the standard around the world.

In addition to Clinical Psychologists possessing the skills and training to treat complex mental health problems, Clinical Psychologists also:

- Provide supervision to Psychologists.
- Provide supervision to newly graduated Clinical Psychologists.
- Introduce and provide training and support in new treatments.
- Provide leadership to the profession and mental health field.
- Bring creativity to the treatment of complex mental health problems.

The loss of the two tiered system will lead to the loss of the Clinical skills, as just described, to the community of Australia. Simply, the loss of the two tiered system will turn back the advancements that have been achieved over 30 years. In a short period of time the skills of the Clinical Psychologist will be lost because there will be no incentive and no career path for Psychologists to train and move to specialisation.

In contrast the 4 year trained Psychologist is restricted in what he/she can do because:

- They do not have the additional training of a Clinical Psychologist.
- Ethical requirements restrict them to treatment of simple straight forward problems with robotic and focused interventions.

- They are unable to supervise Clinical Psychologists in treatment skills.

As noted above, there are mental health patients with straight forward problems that benefit from simple, focused and robotic intervention strategies. However, patients with complex mental health problems, as described above, require far more than offered by the limited skills of the Psychologist.

I recommend that the two tier arrangement be maintained.

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.

In the last two years I have observed that patients from remote rural areas have sought services for treatment of mental health conditions. They have first travelled to Perth to establish a treatment relationship and during this time engage in intensive psychological treatment under the Medicare arrangement. After completion of the intensive treatment, they have returned home and continued treatment via the Internet, using the non - secure software of Skype.

I am aware that remote treatment of patients has been approved for Psychiatrists and Nurses and is advanced in America. Psychological treatment for remote patients via the Internet is not covered under Medicare. This seriously limits treatment availability to these patients. Failure to provide such a service under the Medicare scheme to remotely living patients may also be discriminatory, in that specialised services are denied to these patients unless they are prepared to travel.

It is also the case that many people with mental health problems find it easier to cope and live outside the metropolitan area. Considerable strain is then placed on medical services to provide support and treatment to these patients.

The use of Internet services such as Skype, whilst convenient, are far from satisfactory because connections are often unreliable. Further the use of public software such as Skype does not guarantee security and confidentiality.

I recommend that rebates under the Medicare scheme be extended to cover consultations delivered via Internet to clients who live outside the metropolitan area.

I recommend a secure and Internet service that provides confidentiality be established for patients who live outside the metropolitan area.

Any other related matter

In my capacity as ICP president, I was made aware of a campaign by a group of 4 year trained Psychologists, the Australian Association of Psychologists Inc (AAPi), to collapse the two tiered system and withdraw rebates to Clinical Psychologists.

The argument that has been presented, as I understand, is that Psychologists do the same as Clinical Psychologists. In the event that Psychologists are doing the same as Clinical Psychologists, in every jurisdiction around the world where Clinical Psychologists are recognised, it is considered unethical and dangerous for Psychologists to be working outside their limited area of training.

In the event this claim is being made, then it is fallacious and I urge the Senate Committee to look closely at the motivation behind the claims of any 4 year trained Psychologists, or any others that do not have endorsed Clinical training as detailed by the Psychology Board of Australia, that they are doing the same work as a Clinical Psychologist.

I also urge the Senate Committee to reject any consideration to claims that the community does not need specialist Clinical Psychologists. The community needs the expertise of specialist Clinical Psychologists to treat complex mental health disorders.

As described in the preamble, I worked as a 4 year trained Psychologist and I have supervised 4 year trained Psychologists. I am well aware that there is a large difference between a Psychologist and a Clinical Psychologist in their capacities to conceptualise a problem, consider and understand relevant research that bears upon the problem, apply the correct diagnosis, formulate an individually tailored treatment programme that takes into consideration the guide provided by evidence based research and the needs of the patient and advise other treating personnel in the appropriate ways to assist the patient.

Loss of this expertise will be serious to the Australian public and in a very short time will lead to substantial increase in costs as treatments and support for mental health patients fail.

Dr Darryl Menaglio

References

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Sameroff, A. (2010). A unified theory of development: A dialectic integration of nature and nurture. *Child Development*, Jan/Feb, 81, 6 - 22.