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

Terms of Reference

[b] Changes to the Better Access Initiative

Better Access initiative has been shown to be highly successful, and cost effective. It does not make treatment or economic sense to cut this back. It provides easy access to clinical psychologists, it reaches marginalized groups, and through referral via a GP it minimizes stigma. The GP is often the first point of contact for a patient and with a mental health plan there is a seamless transition to a clinician for appropriate treatment.

ATAPS is an unknown factor at present. It is not known what level of funding will be allocated and there is no guarantee that patients treatment needs will be adequately served. When I contacted GP Network Northside to obtain information they were unable to provide any details re psychology services. Why dismantle a system that is working very well when there is no idea or information available regarding its replacement? There are however some difficulties regarding protocols associated with Better Access that need to be addressed. The administrative requirements to report after 6 sessions and the need for GP permission for ongoing treatment is rigid and cumbersome. It is recommended that reporting be similar to psychiatrists. That is, after the patient is first assessed and regularly as is dependent upon progress and significant changes.

Moreover due to cost saving in ATAPS generalist psychologists are employed rather than specialist Clinical Psychologists. This means that Clinical Psychologists, trained in the psychology of psychiatric disorders, and with the clinical skills to treat moderate to severe mental health problems are not being adequately utilised. It makes no sense when there is a clinical psychology specialization in psychiatric disorders and it is not being utilized in ATAPS due to misguided cost saving which in the long run is not cost effective.

Better Access evaluation

In response to comments regarding the Medicare evaluation, it was noted by the NC that there were many significant research methodological issues that diminished the credibility of the study.

[1] 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.
[2] It did not identify the nature or type of psychological intervention actually provided.
[3] It did not factor in or out medication use by the client.
[4] It did not factor in or out therapy adherence indicators.
[5] 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.
[6] 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.
[7] It did not determine relapse rates by type of psychologist.
[8] It was a self-selected sample of psychologists who self-selected their clients and clinically administered the research questions in session.
[9] It was not subjected to peer review, an important component of evaluating research findings.

Proper research demands a well-designed prospective study aimed clearly at answering specific questions in accordance with established principles of psychological research.

[e] Mental health workplace issues including

[iii]The impact of changes to the Medicare rebates and the two tiered Medicare rebate structure for Clinical assessment and preparation of a care plan by GP'.

[d] Services available for people with severe mental illness and the coordinators of these services

Clinical psychology is the specialization of Psychology in psychiatric disorders. Clinical psychology is regarded worldwide as the discipline best trained and equipped to provide Psychological assessment, treatment and interventions in complex co-morbid cases where treatment needs to be assessed from a thorough formulation and knowledge of evidence based interventions, as well as the ability to apply existing knowledge in individual innovative ways.

In Britain and the United States a 4 year generalist degree is not regarded as sufficient training to practice Psychology. I refer you to the following websites regarding the specialization of Clinical Psychology:

http://www.apa.org/ed/graduates/specialize/clinical.aspx

http://www.clinicalpsychology.org.uk

In Australia Clinical Psychologists due to their extended specialized training 8-10 years, and ongoing professional development, have a specialized skill which distinguishes them from most generalist psychologists who have 4 year training. In America and the UK a 4 year training is not regarded as sufficient to practice psychology.

In Australia the difference between generalist and specialist has been investigated by the Management Advisory Service to the NHS, and determined by a Work Value Case in Western Australia.

I am a specialist Clinical Psychologist working in private practice in Epping, Sydney, NSW. Prior to that I was a Psychologist at Broughton Hall Psychiatric Hospital, a voluntary impatient and outpatient unit. I later moved to the then Royal Alexandria Hospital [RAHC]for Children to the position of Senior Psychologist in the Department of Child and Family Psychiatry. In starting our own family over time I established a private practice. I have extensive experience with child, adolescent and adult psychiatric patients. A considerable number of patients in my practice would qualify as suffering from moderate to severe mental illness. For those suffering from a severe mental illness this often entails a degree of poverty through not being able to hold down a regular job to support themselves financially. As a Specialist Clinical Psychologist attracting the higher rebate of $119.80 rather than the generalist rebate of $81.60 I am able to charge the amount the patient would get back from Medicare without their having to make a gap co-payment. People seen by me with severe mental health issues include those with a childhood history of physical, emotional and sexual abuse, Post Traumatic Stress Disorder, Dissociative Identity Disorder, OCD, alcohol, drug abuse etc. These disorders represent the more severe end of the spectrum for which the clinical psychologist has the skills and specialised training. The clinical psychologist is trained in the assessment, diagnosis and treatment of these more severe disorders. Clinical Psychology is the specialization in psychiatric disorder.

To cut the number of rebatable sessions from 18 to 10 is to markedly impair treatment outcomes for this group. Moreover the suggested removal of the specialist rebate will mean it will not be viable economically to bulk bill. This would significantly disadvantage the most vulnerable and those most in need of the expertise of the specialist clinical psychologist. A reduction of the maximum allowable number of Medicare sessions to 10 would result in clinicians committed to ‘best practice’ refusing to take on clients requiring more intensive Psychology treatment given the impossibility of providing adequate treatment. It would be unthinkable that a surgeon would only half perform an operation leaving the patient at risk and untreated. This raises the ethical issue of taking a patient into treatment when you are unable to provide the appropriate treatment.

This group of patients is vulnerable and at risk. The proposed changes undoubtedly will lead to increased distress, increased risks of self-harm and harm to others. They will turn up in GP practices and outpatients. The GP, not trained in Clinical Psychology, can only provide a ‘Band-Aid’ approach. It is hard to see the cost effectiveness of this. Under treatment thwarts recovery, wastes resources, creates a Band-Aid approach where initial symptoms decrease only to re-emerge later worse or in a different form. How can this be cost effective? Research indicates that this group may need up to 30

– 50 sessions for treatment to be effective. Psychiatrists are able to allocate sessions on the basis of need rather than some arbitrary number bearing no relation to the number of sessions needed in order for treatment to be effective. How can this be cost effective and ethical? Would you be happy if a loved one in your family was denied adequate treatment to alleviate pain and suffering?

Clinical Psychologists should be treated as Psychiatrists are under Medicare, as both independently diagnose and, and treat these client cohorts within the core business of their professional practices.

1 Work Vale Case, Western Australia 2001 -

Work Value is an industrial term referring to the nature and complexity of the work and the minimum industry accepted qualifications required to undertake that work.

No specialisation should be referred to in a manner that creates the appearance of the same level of skill and knowledge as the basic APAC accredited four year training of a generalist psychologist.

I draw your attention to the successful "Work Value" case for Clinical Psychology in Western Australia in 2001 heard by the Full Bench Hearing of the Industrial Relations Commission.

Work Value Document - an IRC (Industrial Relations Commission) endorsed articulation of the calling of Clinical Psychology in Australia and the higher industrial Work Value than the calling of Psychology. This is now embedded within Australia's Industrial Relations Awards.

There are 9 areas of specialization within Psychology. 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 /assessment/rehabilitation, etc; ; for health - clinical health psychology, and health promotion; forensic - forensic mental health, etc).

Regarding specialisation, I wish to re-state that 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.

The NC acknowledges that 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.

The Work Value case was based on the following points:

[1] Effectiveness of treatment of mental health disorders by Clinical Psychologists.
[2] The implications for Clinical Psychology of the increase in multi-morbidity problems of the patients seen in the public sector.
[3] The extension of the role of Clinical Psychology, i.e. into community based treatments.
[4] Advances in the treatment of mental health disorders by Clinical Psychologists.
[[5] Application of Clinical Psychology skills to innovative new areas.
[[6] Additional responsibilities and breadth of activities assumed by Clinical Psychologists.

"Clinical Psychologists have the training and skills required to assess and diagnose conditions when longer term treatment is required, select which treatment modalities are appropriate, provide sophisticated clinical psychology treatments, and know how best to integrate this care with treatment provided by other health professionals."

National Health Service Review of Psychological Services.

In 1989, the Management Advisory Service to the NHS differentiated the health care professions according to skill levels. Skills in this sense referred to knowledge, attitudes and values, as well as discrete activities in performing tasks. The group defined three levels of skills as follows:

Level 1- "Basic" Psychology - activities such as establishing, maintaining and supporting relationships; use of simple techniques (relaxation, counselling, stress management)

Level 2 - undertaking circumscribed psychological activities (e.g. behavioural modification). These activities may be described by protocol

Level 3 - Activities which require specialist psychological intervention, in circumstances where there are deep-rooted underlying influences, or which call for the discretionary capacity to draw on a multiple theoretical base, to devise an individually tailored strategy for a complex presenting problem. Flexibility to adapt and combine approaches is the key to competence at this level which at this level comes from a broad, thorough and sophisticated understanding of the various psychological theories.

The group suggested that almost all health care professionals use level 1 and 2 skills and some have well developed specialist training in level 2 activities. The group went on to argue that clinical psychologists are the only professionals who operated at all three levels and (I quote) "it is the skills required for level 3 activities, entailing flexible and generic knowledge and application of psychology, which distinguishes clinical psychologists..."

This is consistent with other reviews which suggest that what is unique about Clinical Psychologists is his or her ability to use theories and concepts from the discipline of psychology in a creative way to solve problems in clinical settings.

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.

For people in remote and rural areas there are significant difficulties in accessing help for a mental illness. They often have to travel to cities where there are mental health resources which involves time away from their families [source of support] and significant financial barriers. Ongoing help is a real problem.

Some patients attempt to access treatment via Skype, however connections are often unreliable the use of public software does not guarantee confidentiality and security. Remote treatment of patients occurs in America.

Increasingly new technology makes the delivery of mental health services feasible to this group of patients. At the present point in time however Medicare rebates are not available for Clinical Psychologists for treating patients except in face to face consultations. This results in people having to travel, in some cases, several thousand kilometres to access Psychological services. This is impractical. Is it surprising that the rural suicide rate is so high in remote and rural locations. This matter urgently needs to be addressed.

Summary And Recommendations:

[1] Retention of the 2 tier system which recognizes the specialization of Clinical Psychology and its role in the diagnosis and treatment of moderate to severe mental health illness.

The UK and America recognize the specialization of Clinical Psychology. A 4 year trained graduate cannot practice Psychology as the qualification is deemed inadequate.

[2] In Australia the Psychology profession has developed over the years to the point where there are recognized specializations in Psychology and increasing professional standards. For those older Psychologists who did their training when only a 4 year degree was available there should be a means by which there skills can be assessed and if they can demonstrate
appropriate Clinical Psychology skills a grandfather clause should be applicable.

[3] With patients with severe mental illness it is recommended that up to 50 sessions be allocated as it is with psychiatrists. Psychiatrists are able to allocate sessions on the basis of need and number of sessions required for treatment to be effective. To undertreat is to potentially do more harm and will result in increasing numbers of presentations involving GP's, outpatients, police, community services and mentally ill people in custody. The mentally ill are already overrepresented in the prison system. This is hardly cost effective.

[4] Better Access already provides services for people with moderate to severe mental illnesses. I don't think it has been recognised just how many patients with a moderate to severe mental illness are being seen through Better Access. It would make economic sense to increase their funding levels.Better Access has been shown to be highly effective and cost effective.

[5] The effectiveness of ATAPS is unknown. We do not know what level of funding has been made available, or if they are able to absorb the significant numbers they will be required to provide for, Moreover due to cost cutting Clinical Psychologists availability is under utilized. As recognised, Clinical Psychologists specialize in the diagnosis and treatment of moderate to severe psychiatric disorders. How can their lack of presence be cost effective?

[6] Medicare rebates are not available for Clinical Psychologists for treating patients except in face to face consultations. It is recommended that Medicare rebates be made

available for consultations via the internet for patients in remote rural areas, as it is for psychiatrists and nurses.

[7] The provision of a secure internet network to provide for confidentiality and patient treatment.

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