

4th August, 2011

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

Dear Senator,

Re: Government proposal to cut the '*Better Access to Mental Health Initiative*' to 10 sessions, and enquiry into the two tier method of funding for psychologists.

I am writing to express my objection to three matters: (1) The Government's proposed changes to the number of sessions available to clients of psychologists under the Better Access to Mental Health Care Initiative (*'Better Access Initiative'*) as announced in the 2011 Federal Budget, (2) the assumption that clients with moderate to severe mental health issues will have all their needs met by an ATAPS facility, and (3) the Government's consideration of abolishing the current 'two-tiered' system of Medicare Rebates to psychologists. I will address these (and other) issues in turn.

1. Proposed reduction to the number of sessions from a maximum of 18 to 10 in a calendar year.

At the time of the introduction of *The Better Access Initiative*, the 12 sessions allowed (with another six sessions for those with 'exceptional circumstances') was considered an arbitrary figure by those with experience in dealing with clients with moderate to severe mental health issues. However, the unexplained allocation of the 12 sessions was overlooked as it was a ground-breaking change to the previous options available to people with mental health disorders, viz., pay privately (which of course most clients could not afford), or be put on a wait list for months to see a staff member in a community health centre or a Division of GPs who was not necessarily trained in psychology, let alone clinical psychology.

To reduce the number of sessions available under this initiative flies in the face of evidence that is widely available (for example, see Harnett, O'Donovan, & Lambert, 2010)¹, when guidelines/outcome studies often suggest a minimum 9 to 10 sessions (e.g., for panic attacks), to more than 20 sessions for single issue disorders. The reality is that many of the clients seen by clinical psychologists do not have single-diagnosis, easily "managed by a treatment manual" disorders. They have multi-layered chronic and comorbid disorders such as anxiety (including OCD, which is notoriously difficult to treat), depression with suicidal ideation, post traumatic stress disorders or bipolar disorders, combined with personality disorders, substance

abuse issues and other psycho-social problems such as reduced access to educational/occupational pathways, and poor relationship or parenting skills. These issues require the clinician to develop individual treatment plans utilising a wide range of therapeutic skills, following a full assessment and the development of a mutually trusting and collaborative relationship, all of which takes some time.

Further, it is not uncommon that complex psychological issues are not always evident on first or early presentation, and it may take a number of sessions to obtain sufficient information to assess and determine an appropriate treatment plan. For example, a relatively straightforward referral I received (as presented to the GP) for anxiety that prevented a qualified teacher from working, has revealed a case that is a multi-layered study of systemic and traumatic psychological and physical abuse from earlier involvement in a particularly authoritarian and abusive religious sect. This facilitated the client's misguided loyalty in tolerating current domestic violence and not speaking of it. It took much longer than 10 sessions for this client to reveal the full nature of what she is enduring, and for me to help her address the issues that are maintaining her anxieties. After more than a year of treatment, and more than 18 sessions, we are now considering a return to work, which will be a beneficial outcome for the client and the society as a whole - all for a little over \$2000.00 (I bulk-bill).

As the evidence suggests more (rather than fewer) sessions are needed to achieve long lasting recovery, to expect clinical psychologists to deliver an intervention in 10 sessions runs the risk of diluting the treatment integrity of these 10 sessions, resulting in delayed recovery and the risk of further costs later down the track as clients relapse. Further, such a restriction on services is not placed upon other medical providers, especially psychiatrists.

Finally, the suggestion that clients who need more than 10 sessions may be able to access psychiatrists is farcical, and all I can say to those who need to find one quickly is "good luck!" Psychiatrists rarely bulk bill, have long waiting lists, and often do not provide evidence-based therapy, but rather only provide and monitor pharmacological treatments. The cost to the Medicare system is also greater for their services than seeing a clinical psychologist.

In summary, to reduce the number of sessions available from a maximum of 18 to 10:

- *is not based evidence-based best practice;*
- *lacks understanding of the nature of the complex difficulties facing a number of clients;*
- *runs the risk of increasing mental ill-health through inadequate or truncated treatment protocols;*
- *is discriminatory to a significant workforce in the mental health sector (psychologists) compared to other health professionals (e.g., psychiatrists), and*
- *may eventually lead to higher cost outcomes, either due to prolonged ill-health and lost productivity etc, or by resorting to using higher cost health professionals such as psychiatrists.*

2. Assumption that clients with moderate to severe disorders are best served by an ATAPS facility.

I note that it is intended that psychologists can continue to treat those clients who are regarded as having a mild to moderate mental health disorder, whilst others with more serious disorders should be seen at an ATAPS facility. Who is to make this distinction, and when?

Firstly, as mentioned above, not all complex psychological issues are always evident on first or early presentation, and GPs are not the most qualified, nor do they have the time, to obtain a complete history and mental health diagnosis. In the case I described above, I doubt this outcome would have been achieved if I had to interrupt treatment and refer on to another agency, such as an ATAPS facility.

Secondly, I have worked in several ATAPS-type organisations under *The Better Outcomes for Mental Health* initiative. These organisations had differing inclusion criteria for the kinds of disorders seen, and all had differing approaches to the number of sessions available to clients, and whether there were gap payments involved. Employment conditions for staff varied widely. Naturally, consistency in outcomes for clients also varied widely, and in all cases, there was considerable funding spent on administration and infrastructure, in essence taking funds away from treatment provision.

I also know from experience that the tendency is to employ lower qualified staff under the title of “mental health clinician”, who are not necessarily psychologists, and may include those from occupations not registered by the Australian Health Practitioner Regulation Agency (AHPRA). There is usually a significant staff turnover as the staff gain some experience then move on to better paid positions. Therefore, under the changes proposed to the *Better Access Initiative*, it is likely that the client who has the greatest need will not necessarily receive the most skilled, nor the most consistent, treatment.

I have also worked for many years in Federal Government health and welfare agencies, and am very cognisant of the tendency towards centralising services and then decentralising them, then re-centralising them again, all at considerable cost to the taxpayer, and confusion to the client over who is supposed to provide what service. I fear the same will occur under the ATAPS model of service provision for mental health services, and the funding for scarce mental health resources will be eaten up in maintaining bricks and mortar and ever-increasing layers of administration.

In summary, the intention to save costs by redirecting funds from privately practising Clinical Psychologists to other ATAPS agencies for treatment of those who need more than 10 sessions is based on faulty logic, as:

- *It is often hard to accurately predict at either the time of referral or the beginning of treatment who these clients may be;*
- *The clients who need the most skilled and consistent psychological*

interventions are more likely to receive services from less skilled and more transitory ATAPS therapists, and

- *The creation of many alternative little bureaucracies will deflect much needed funds from service provision to administration.*

3. The review of the two-tier rebate for psychologists.

The review into the two-tier system for psychologists raises the spectre that clinical psychologists should not be adequately compensated for their skills by receiving a higher Medicare rebate for their services. If this were to become the case, the sheer hypocrisy would be breathtaking, and should prompt a review of all the other accepted, well entrenched two-tier systems already in existence under the Medicare system, e.g., GPs and other specialists such as cardiologists, psychiatrists, gynaecologists, etc.

As with medicine, there are many specialties within psychology, and Clinical Psychology is the only profession, apart from Psychiatry, whose entire accredited and integrated postgraduate training is specifically in the field of mental health. The higher degree covers advanced evidence-based and scientifically-informed psychopathology, assessment, diagnosis, case formulation, psychotherapy, psychopharmacology, clinical evaluation and research across the full range of lifespan, plus 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.

Currently, there are two groups of psychologists recognised by Medicare – those who have gained endorsement as a “clinical psychologist” - and all the others, who are classified as “generalists”.

“Generalists” may include those with Masters or Doctorate degrees who are not trained in clinical psychology, but in some other specialty. Ethically, they should not be treating clients with mental health disorders, and should not expect a higher rebate under an initiative that is purely to assist those with mental health disorders. Similarly, clinical psychologists would not expect to be rebated at the same level as other psychology specialists, should some specific funding become available for that particular area.

“Generalists” may include those who are trained in a Masters or Doctorate degree in clinical psychology, but have not yet completed the post-graduate supervision requirements necessary to gain the appropriate endorsement. As they do not yet have the required skills, it is inappropriate to pay them as if they do.

“Generalists” may also include those who are registered under an earlier method called the “4+2” (four years at university plus two years supervision). While there are no doubt many experienced and capable psychologists registered under this method, the reality is that the supervision method was often less rigorous, and depending on the nature of the principal (supervising) psychologists’ business, not necessarily clinical. Again, it is not appropriate to

pay a higher fee to a psychologist who has not demonstrated their clinical expertise through some form of higher education and standardised assessment process, as is done by clinical psychologists.

Further, there has been plenty of time for those less qualified to gain additional qualifications. When I began studying psychology about 20 years ago, it was made quite clear then that the “4+2” form of registration was to be phased out, as it was argued even then that no other country had such minimal professional and academic requirements for psychological practice. Access to places in Masters programs became competitive, and only the academically more qualified students were accepted. Nevertheless, most programs made some places available for psychologists registered under less stringent conditions to enable them to upgrade their skills, and many took advantage of this opportunity to increase their skills and employment opportunities. Those who did not expend the time, money and effort should not now expect to be treated as though their achievements are the same.

Further, while these 4+2 “generalist” psychologists may well argue that their skill level and experience is the same (and I am sure that is the case in many instances), there are many examples in other walks of life where a consumer relies on evidence of greater professional competency, for example, accountant vs book-keeper; master builder vs handyman. To take the analogy further, whilst electricians and plumbers are all engaged in the building trade, a consumer will not phone an electrician to have a tap replaced (despite there no doubt being some handy individuals who may have the practical skills to do both) – it is a question of *recognised and licensed* qualifications.

It is therefore appropriate that as the *Better Access to Mental Health Initiative* is focused on obtaining the best outcomes for clients with mental health disorders, those psychologists who are trained to deal specifically with this client group (i.e., clinical psychologists) are appropriately recognised and paid for their expertise, as opposed to other psychologists who have other skills in other areas.

In summary, the two-tier structure that provides greater financial recompense to clinical psychologists compared to generalist psychologists should remain, as:

- *To remove it would create a precedent that would have ramifications for other well established fee differentials that already apply in the Medicare system;*
- *Clinical psychologists are the equivalent in the practice of psychology for mental health disorders as are other specialists in the medical system,*
- *Clinical psychologists are the only psychologists specifically trained in providing assessment and treatment to those clients with mental health disorders, and*
- *Clinical psychologists have gained their status through higher, more rigorous and standardised academic qualifications (with documented and supervised practical experience) than “generalist” psychologists.*

4. Other Issues

The success of the *Better Access to Mental Health Initiative* has indicated the very great need for **better, faster, and more targeted services** to be made available to people with mental health problems than had existed before. However, I understand that ongoing funding is an issue.

One suggestion to reduce the costs in this area is to reduce the requirements upon doctors to produce lengthy referral documents, and remove the need for the six-session review.

In my opinion, the extensive referral proforma given to doctors by the Divisions of GPs rarely throw any significant light upon the nature of the problem, and those doctors who may use a screening test to check mood do not analyse it to any significant degree.

Several years ago I had to contact a medical practice as they were using a DASS21 provided by their local Division of GPs that was incorrectly coded. The implications for incorrect medications (i.e., providing anti-anxiety medication instead of anti-depressants) were obvious. Luckily, the doctors involved relied on their own clinical interviews and assessments to determine appropriate medication, and the paperwork was an irrelevant side issue for them. As it is, I conduct my own mood screening as well (I prefer the DASS21 to the K10, as it provides more clinically relevant information).

Doctors should be permitted to refer to clinical psychologists in the same manner that they refer to other specialists – a simple and short letter, with relevant and pertinent facts included. They would then charge the appropriate Medicare item number, based on time spent for this simpler process. This would also hopefully obviate the need for the client to attend doctors' rooms several times (I have been told up to three visits may be required to complete and collect a referral), thus reducing costs to Medicare.

Secondly, the 6-visit review visit to the doctor is not warranted, as the time relevancy varies considerably. It may be that the review is due within a few weeks of the initial referral (depending on whether the client and clinical psychologist are dealing with a crisis situation, e.g., threatened suicide, and need to see each other frequently), or over several months. I have found that in any case, many clients are being reviewed by their doctor for other matters (such as medication), and this is often done within a few weeks (i.e., a specific time frame, rather than a per-visit-to-the-psychologist time frame).

Secondly, the 6-visit review visit has never, in my experience, resulted in additional sessions being refused, as most doctors understand that lasting change and/or recovery for most mental health disorders takes more than six sessions. It would be far more appropriate and cheaper for the *Access to Better Mental Health Initiative* if referrals were similar to referrals to other specialists, i.e., for 12 month periods. However, the existing requirement that doctors authorise in excess of 12 sessions could remain. In practice, clinical psychologists and treating doctors liaise by phone if there is any significant

issue that the other needs to be briefed about in a timely fashion.

In summary, costs to the Access to Better Mental Health Initiative would be curtailed if:

- *Referring doctors were allowed to simplify and streamline their referral process, and*
- *The current requirement for a 6-session review was abandoned.*

I trust that my feedback will be given due consideration.

Yours sincerely,

(Name withheld)
BA(Hons); MPsych(Clin)
MAPS

ⁱ Harnett, P., O'Donovan, A., & Lambert, M. (2010). The dose response relationship in psychotherapy: Implications for social policy, *Clinical Psychologist*, 14(2) pp. 39-44.