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Commonwealth Funding and Administration of Mental Health Service
Senate Inquiry: Community Affairs Reference Committee

This submission has been written by (Clinical Psychologist) on behalf of, and with the contribution of, a group of Specialist Clinical Psychologists at Melbourne Children's Psychology Clinic (MCPC) who are listed at the end of this submission. MCPC is a private practice located in Brunswick and Hampton that provides psychological services under Better Access Initiative Scheme to infants, children and adolescents ranging from 0 to 18 years in age, and their parents/families. All MCPC psychologists are Specialist Clinical Psychologists (as endorsed by the Australian Board of Psychology) with specific training and expertise in Clinical Child and Adolescent Psychology. (Principal psychologist at Brunswick) and (Principal psychologist at Hampton) are founding members of the Australian Clinical Psychology Association and wish to overt their membership to this association.

Clinical psychologists:
"Although often grouped with Allied Health for administrative purposes, Clinical Psychologists differ in many ways from other Allied Health professionals. No other allied mental health professional receives as high a degree of education and training in mental health as the Clinical Psychologist. Other than psychiatry, Clinical Psychology is the only mental health profession whose complete post-graduate training is in the area of mental health. Furthermore, it is the only discipline whose complete training is in psychology, that is, both at the undergraduate and post-graduate level. In other words, the Clinical Psychologist is completely trained in a science intrinsic to mental health." (1998, Work Value Document, Western Australia Clinical Psychology Health Sector, p.30).

Moreover, qualified clinical psychologists have extensive accredited post-graduate training in mental health (comprising of course work, clinical placements, and a substantial research component) followed by a supervision period, matched only by psychiatrists.

A number of MCPC psychologists have completed the Doctorate in Clinical Psychology with Child Specialisation, whereby the entire three year post graduate doctoral course focused the social,

emotional, behavioural, developmental, cognitive and neurological issues unique to children and adolescents. We wish to highlight that issues pertaining to this clinical group are qualitatively different to adults and require specialist knowledge.

MCPC is in full support of the submission made by the Australian Clinical Psychology Association (ACPA) and have chosen to address only some of the terms of reference to contribute information as relevant to our client group and specific area of expertise, practice and knowledge being:

(a) The Government's 2011-12 Budget changes relating to mental health
(b) Changes to the Better Access Initiative, including:
(ii) The rationalisation of allied health treatment sessions and two tiered Medicare rebate system for psychologists.
(iii) The impact of changes to the Medicare rebates and the two-tiered rebate structure for clinical assessment and preparation of a care plan by GP.
(iv) 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.
(j) Other related matters: Evidence-based child and adolescent therapy sessions with identified patient not present.

(a) The Government's 2011-12 Budget changes relating to mental health

As noted in the Draft Version of the

. Senate Inquiry: Community Affairs References Committee:

> The package of measures announced in the 2011 budget for funding mental health included the headline figure of $2.2 billion, but only $583 million is to be spent over the forward estimates (the next four years). In the 2011-12 financial year the total amount to be spent is only $47 million. It appears the Government is in fact cutting mental health funding by removing $580.5 million from GP mental health services and allied health treatments sessions from the Better Access Initiative.
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> ...While additional investment in child and youth mental health is vital, we are concerned that 85% of the $491.7 million funding to boost services for children and young people has been allocated to two models of care - EPPIC and Headspace – to the exclusion of other treatment programs which may also be of significant value to the broader community, and which may have a more substantial evidence-base. Additional funding for those patients with severe and persistent mental illness is another important initiative, but it is disappointing that the value of services provided by private clinical psychologists to these individuals under the Better Access program has been ignored. We also believe that there are significant gaps in the government's "expanded" mental health care program, with no mention made of the needs of the substantial portion of patients with mental health diagnoses of moderate severity, who require psychological therapy but do not necessarily need or want to access public health or psychiatry services, and may be better served by clinical psychologists under the Better Access program.

The EPPIC program is tailored to a specific client group "addressing the needs of people aged 15-24 with emerging psychotic disorders" and that it is estimated that only 2% of people will experience a psychotic episode at some stage in their life (http://www.eppic.org.au/, cited 23/07/2011). This is a significantly small proportion of children and adolescents compared with estimates of anxiety, depression and other common childhood disorders that cause significant distress and significantly impact on daily level of functioning. For example, Dadds et al., (2000) noted twelve month prevalence rates ranging from 17% to 21% in childhood anxiety and furthermore, that around 8% will be significant enough to require treatment (Anderson, Williams, McGee & Silva, 1987; Kashani & Orvaschel, 1988; Bernstein & Bochardt, 1991; Kashani & Orvaschel, 1990; Kashani& Orvaschel, 1998; Spence & Dadds, 1996, cited in Dadds et. al., 2000).

Whilst Headspace offers services to a wider group of clients, it is aimed at providing services to children and young people aged 12 to 25 years, and like our current community mental health services, will have limited capacity to meet the growing need of children and adolescents with mental health issues in Australia.

Hence infants and children aged 0 to 12 years of age have been severely neglected in this budget which is inconsistent with the government's commitment to early intervention and prevention. Furthermore, the majority of clients referred to MCPC are under 12 with a significant proportion 4 years and under, indicating that there is a high need for services in the community for this client group. It is well accepted that the quality of care provided in the early years of life (essentially the first three years) shape the developing brain and can have a fundamental impact upon the child's future vulnerability to mental health issues; hence it is critical that resources are accessible to families for this age group.

There has previously been no distinction made between mild, moderate or severe presentations of mental illness under the Better Access initiative. However, in the 2011-2012 Budget funding was transferred from the provision of private psychological services into public sector child and youth mental health programs for severe mental health issues (as referred to above). The Better Access scheme now distinguishes between mild, moderate and severe presentations[1] and hence has removed those children and families with greater need from access to private treatment in the community by their choice of practitioner. Individuals with more severe illnesses are to be referred to either:

1. the ATAPS program, which is limited in focus, more expensive, and restricted in choice for the consumer;
2. to psychiatrists, where there is a distinct shortage, particularly in low SES and rural areas, and significant co-payments are commonly demanded; or
3. to the public sector, which treats only those with the most severe and persistent mental health problems. Therefore, the more mode rate – severe or chronic presentations require

[1] We note there is a clear lack of workable definitions for mild, moderate and severe presentation of mental health.

> greater services, but under the changes announced will be provided with fewer options, greater restrictions and poorer access to services.

We wish to highlight the inadequacies of these options in relation to cost effectiveness, client accessibility, and the therapeutic needs of our client group.

The ATAPS Program

In relation to ATAPS, the APS has stated:

> The Government's own evaluation of Better Access demonstrated that it is a cost-effective way of delivering mental health care. The typical cost of a package of care delivered by a psychologist under the initiative is $753, significantly less than ATAPS which costs from two to 10 times that of Better Access per session. Successful treatment also reduces costs of hospital admissions and allows many consumers to return to work, with the associated productivity benefits (APS, 2011).

Furthermore, we wish to highlight that the ATAPS program is restricted to the provision of Focussed Psychological Strategies (FPS) that can be delivered by psychologists and other allied health professionals (Department of Health and Aging, 2010, p. 5). This program is therefore unable to meet the needs of those patients with more chronic or severe mental health problems that require services provided by clinicians with advanced clinical knowledge of assessment, diagnosis, formulation and treatment, such as psychiatrists and clinical psychologist, to ensure they receive more suitable evidence-based treatments tailored to their needs. Under the current proposal, to treat those with more moderate to severe presentations under ATAPS program, means to have the more vulnerable treated by a workforce that includes psychologists without specialist qualifications or specialist training in mental health, who are only able to use short term focused psychological strategies.

The APS has further stated:

> The ATAPS program run through the Divisions of General Practice (DGPs) is not a viable referral option under current arrangements. There is simply not enough funding in ATAPS to provide services for anything like the number of 260,000 people (or 86,000 per annum). A major issue is that a significant proportion of the funding for mental health services received by DGPs is spent on administration rather than providing funding to the psychologists who are engaged to deliver the services. As a result, frequently more junior psychologists are selected to provide services and more experienced psychologists cannot viably undertake the work (APS, 2011).

Furthermore, states that:

> Much of the newly announced ATAPS funding is for the Tier 3 funding ("severe and persistent" mental illness). We have been advised by the College of Clinical Psychologists of the APS that, once programme-related overhead and administrative costs are deducted,

there remains only provision for an approximately 0.8 EFT salaried clinical psychology position within a Division that can be dedicated to the Tier 3 program. Given the additional cost of employment of clinical psychologists, many Divisions choose to employ less qualified psychologists at a lesser cost. Thus, to have those with more moderate and severe presentations treated under ATAPS, means to have the more vulnerable treated by a workforce without specialist qualifications and training, utilising short-term strategies.

The author wishes to note that from her own discussions with her local GP Division

, she has been informed that Melbourne General Practice Network do not currently accept any patients that have the resources to access private services under The Better Access Program. Hence, they rely heavily on the Better Access Program such that they routinely refer patients out at point of referral.

Psychiatry

Access to child psychiatry in our local community is extremely limited with very few child psychiatrists servicing the North West region. MCPC-Brunswick has had clients report waiting times in excess of five months to attend reviews with their psychiatrists. We imagine that this problem of a profound shortage of child psychiatrists is even more significant in rural and remote areas.

It has also been noted by our clients that many psychiatrists have large gap fees which makes them unaffordable to a significant proportion of our client group; around 30% of our clients at MCPC-(both Brunswick and Hampton) are health care card holders.

In addition, whilst psychiatry has a major role to play in older adolescent and adult populations given their unique role in medication, this treatment is neither appropriate nor indicated in the vast majority of child and infant disorders of mental health, thereby placing clinical child psychologists as equal experts with respect to this specific client group. Moreover the expertise and potential contribution of clinical specialist psychologists (and more specifically, clinical specialist psychologists with specialisation in child clinical psychology) has been largely overlooked by this budget.

The Public Sector

It is our understanding that children who are not acutely at risk (e.g., acute suicidal risk, acute onset of psychosis) are often placed on significant waiting lists in public community mental health settings, and families are strongly encouraged to seek private services if possible. Consistent with this, MCPC – Brunswick currently receives around 25% of referrals from families who have initially contacted the local public mental health services (Austin Child & Adolescent Community Mental Health and Royal Children's Hospital Mental Health Service) and have been directed to seek a private service first. We have always accepted these children and adolescents that predominantly present with moderate to severe presentations (with MCPC clinicians sometimes working in collaboration with child psychiatrists who provide psychiatric reviews as required), but would be unable to continue to ethically service this client group under the limit of 10 sessions. We also receive a high number of

referrals from paediatricians and psychiatrists that are often moderate to severe presentations. We further believe that we would be no longer able to accept the majority of these referrals under the new cap of 10 sessions.

The public mental health outpatient services within the MCPC-Brunswick region are highly stressed and lacking resources. Whilst we encourage any increased funding to support these services, we believe that reducing the number of sessions to the Better Access program will place an excessive pressure on this system and they simply won't be able to meet the increased need. Many clients will go without a service.

From our personal experiences of working in the public sector, it is our opinion that waiting lists in our local public mental health services for children and adolescents were excessively long prior to the Better Access Program (at times in excess of 12 months) and have considerably reduced since the introduction of the Better Access Program.

In summary, all of the options noted above are considered inadequate to meet the needs of moderate to severe patients within our client group (0-18), with an even further inadequacy of funding and services available for the 0-12 year-old group of infants and children.

(b) changes to the Better Access Initiative, including:

(ii) The rationalisation of allied health treatment sessions and two tiered Medicare rebate system for psychologists

As the current Better Access program stands, allied health professional and non-specialist psychologists are funded to provide "Focused Psychological Strategies" which we believe matches the therapeutic needs of infants, children and adolescents with mild psychological problems and *may* (though in some cases may not) match the needs of infants, children and adolescents with moderate levels of mental health problems. Only Specialist Clinical psychologists are funded to provide tailored "Psychological Therapy" programs which is appropriate given:

- qualified clinical psychologists have extensive accredited post-graduate training in mental health followed by a supervision period, matched only by psychiatrists, and
- the evident shortage of private psychiatrists and the high co-payments required for their services.

This differentiation in services delivered within each tier appropriately reflects the vast difference in training between clinical specialist psychologists and non-specialist psychologists (and other allied health). It is further argued that clients with severe presentations (and in many cases moderate presentations[2]) are best seen by Clinical Psychologists due to their advanced training and expertise that enables them to provide assessment and psychological therapy to patients with complex presentations.

[2] We wish to highlight the lack of clear definitions to date of mild, moderate and severe mental health presentations.

It has been a common experience in our practice that GP's are not able to clearly discriminate between clinical specialist psychologist and other psychologists and allied health and nor are they often aware of the differentiation between focused psychological strategies and psychological therapy.

It is further noted that the current assessment model implemented by GP's, consisting of a brief clinical interview and the use of the K10 *screening* tool, is not adequate to predict a child's treatment needs in relation to severity and chronicity and hence limits the GP's ability to adequately refer to the appropriate services (ie., psychological focused strategies versus psychological therapy). This issue is discussed further in section (b) (iii).

Recommendations:

- We recommended that better assessment tools be utilised by GP's for infant, child and adolescent patients to assess complexity and chronicity that can better inform and assist GP's to refer for either "Psychological Focused Strategies" or "Psychological Therapy" and
- We recommend that a specific referral base of clinical specialist psychologists be available to GP's to assist them to clearly differentiate psychologists/allied health from clinical specialist psychologists.
    - We further recommend that the data base highlight clinical specialist psychologists that have completed a Clinical Masters or Doctorate level qualification with Child and Adolescent Specialisation to assist in appropriate referral pathways for infants, children and adolescents.

(iii) the impact of changes to the Medicare rebates and the two-tiered rebate structure for clinical assessment and preparation of a care plan by GP

We wish to highlight some of the inadequacies of the current GP referral model with relation to infant, child and adolescent clients.

We are concerned that GP's are considered best placed to "diagnose" and develop a "treatment plan" for infants, children and adolescents. Furthermore, we believe that GP's are in a difficult position to ascertain whether a patient will most likely require an intensive and advanced therapeutic intervention currently provided by specialist clinical psychologists, or whether they can appropriately be referred for focused psychological strategies (as appropriate for mild and possibly moderate presentations of child and adolescent mental health).

As clinical specialist psychologists with expertise in child and adolescent clinical psychology, we work from the international gold standard assessment framework (Sattler, 2006) that includes:

- a comprehensive individual child assessment interview (including observation, clinical interview, drawing and projective testing)

- a comprehensive parent interview (including analysis of family of origin, parenting and attachment style, and a complete child developmental interview)
- where clinically indicated, a teacher interview and/or structured questionnaire

This information assists us to develop a comprehensive case formulation that guides treatment planning.

The current assessment model that is conducted by GP's (consisting of a brief clinical interview and the use of the K10 *screening* tool) is not adequate to diagnose a mental health condition, form a treatment plan, or predict treatment needs of severity, in infants, children and adolescents. The prediction of treatment needs (and in fact, a formulation and development of a treatment plan) can only be anticipated after a comprehensive assessment. We further note that the K10 is developmentally inappropriate and insensitive to a significant number of issues evident in infant and child mental health populations.

Whilst we support the current referral method for mild presentations that match the need for "focused psychological strategies" provided by non-specialist psychologists and allied health professionals, we argue that only a referral letter be required from GP's to specialist clinical psychologists who are best placed to complete a thorough assessment of moderate to severe complex presentations that inform sound treatment plans.

In addition, we query the cost effectiveness and therapeutic appropriateness of GP MHCP reviews. The reliability and validity of GP reviews is questionable given that the best placed person to review the progress would be the treating clinician, and that their opinion would be based upon multiple sources (teacher report, parent report, client self report and clinician report). Furthermore, given the GP "refers to a specialist", it then seems counter-intuitive to refer back to the GP for a review of a "specialist intervention". Put another way, if a GP refers to an oncologist for concerns relating to melanoma, the specialist is not going to refer back to the GP to clarify the type or number of "treatments" required. In addition, we strongly believe that clinical psychologists adhere to their professional code of conduct and code of ethics and that it would be an extreme exception for a specialist psychologist to knowingly provide a service to a client that no longer required one.

Recommendations:

- We recommended that better assessment screening tools be utilised by GP's for infant, child and adolescent patients that are both developmentally appropriate and sensitive to mental health issues evident in this age group,
- That GP's only be required to write a referral letter to specialist clinical psychologists that:
    - Recognises both the need for a comprehensive assessment to inform treatment planning with respect to infants, children and adolescents,
    - Acknowledges that clinical specialist psychologists are best placed to provide comprehensive assessments of this client group given their skills and expertise in the assessment and treatment of complex clients (moderate to severe), and

- Reduces the doubling up of workload given specialist clinical psychologists must ethically conduct an assessment of a patient prior to providing psychological services.

- That the current referral system of GP's developing a Mental Health Care Plan remain in place for the referral of mild presentations to non-specialist psychologists and allied health for "psychological focused strategies".

(iv) 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

As previously noted in section (b)(iii), a child assessment requires the integration of information from a number of sources (the child, the parent, and in some instances, the school). It is argued that a minimum of two sessions is required in any sector (private or public) to ascertain the minimal information necessary for an informed formation and treatment plan. We are concerned that a decrease in sessions (from 12 standard sessions to 10 standard sessions) encourages poor practice. We further note that a well developed case formulation based on good assessment is likely to lead to a more relevant /focused treatment intervention with therefore greater clinical effectiveness and outcomes.

Psychological therapy interventions with infants, children and adolescents often require working with multiple systems, as informed by the case formulation. We often work simultaneously with the child and/or parent-child dyad, the parent, and, where necessary, the teacher. We wish to highlight this in relation to the impact of a limit of 10 sessions such that our capacity to work with multiple systems will be significantly reduced.

In relation to the rationale to reduce sessions, we wish to highlight:

- The fatal flaws of the Evaluation of the Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule (May, 2011) survey (we refer the reader to the ACPA (2011) submission.
- That such changes will impact on the most vulnerable client group with a lack of client accessibility and resources provided by ATAPS, psychiatrists, and the public sector for our client group (as noted in section (a)) and,
- The majority of studies assessing the effectiveness of CBT for child and adolescent anxiety and depression are based on more than 10 sessions (often consisting of 10, 16 and 20 session programs, for example: Barrett, Dadds & Rapee 1996; Kendall, Flannery-Schroeder, Panichelli-Mindell et al.,1997, Kendall 1994). Refer to Dadds, Seinen, Roth and Harnett (2000) for an overview of studies evaluating the effectiveness of CBT and childhood anxiety.

Allowing clinical specialist psychologists to provide the number of treatment as required will arguably reduce the likelihood of relapse, increase the likelihood of good long term outcomes, and reduce the overall long term cost of mental health on the community.

Finally, as previously noted in section (a), public mental health services within our region (e.g.,Austin Child & Adolescent Community Mental Health and Royal Children's Hospital Mental Health Service) routinely direct the families of *a child without an acute mental health risk*, to seek a private service first. Children and adolescents that have been encouraged to contact our clinic via the public health service have always, to date, had moderate to severe symptoms (e.g., suicidal ideation, self harm behaviours, significant anxiety, PTSD symptoms, and significant trauma). As previously noted, MCPC-Brunswick has always accepted these children and adolescents with moderate to severe presentations (with MCPC clinicians sometimes working in collaboration with child psychiatrists who provide psychiatric reviews as required), but would be unable to continue to ethically service this client group under the proposed limit of 10 sessions. MCPC-Brunswick also receives a high number of referrals from paediatricians and psychiatrists that are often moderate to severe in presentation. We would be no longer be able to ethically accept the majority of these referrals under the new cap of 10 sessions.

We hope that the government can consider the inevitable impact of the budget cuts on the public sector and hence the huge number of children and families that are likely to go without an adequate service.

(j) Other related matters: Evidence-based child and adolescent therapy sessions with identified patient not present.

As we have previously noted in section (b)(iii) that a parent interview (which includes: analysis of family of origin, parenting and attachment style, and child developmental interview) is a necessary component of a comprehensive assessment required to guide effective and efficient treatment interventions for infants, children and adolescents. A parent interview is recognised internationally as the gold standard and that anything less compromises the quality of services provided by specialist clinical psychologists.

We also wish to highlight that superior outcomes have been found in relation to a number of childhood disorders when parent involvement has occurred in addition to a child based interventions including childhood anxiety, attention deficit hyperactivity disorder and child attachment disorders (e.g., Dadds et. al, 1999; Barrett et al. 1996; Cobham, Dadds, & Spence 1999; Becker-Weidman & Hughes, 2008). This may either be due to parenting factors playing a significant role in the onset and maintenance of a childhood disorder and/or whereby therapeutically informed parenting skills may be viewed as a significant facilitator of change for good therapeutic outcomes (such that parents implementing changes to the child's environment can, at times, have a far greater impact than a therapist spending an hour per week with the child).

There are also a range of clinical situations where it is inappropriate and/or potentially psychologically harmful for a child or adolescent to be present during a parent session at either the assessment and/or intervention phase of treatment. Of particular concern is that restricting funded sessions to always having the identified patient is present can result in vital information regarding patient safety not being communicated to the psychologist by a parent or guardian, with potentially serious consequences.

In summary, individual parent/guardian sessions (without the patient present) are not correctly funded under the Better Access program which:

- Prevents minimal standards in infant, child and adolescent assessment
- Reduces optimum outcomes given research has demonstrated superior outcomes for interventions involving a parent intervention for a number of childhood disorders, and
- Can place the child at risk if parent-therapist communication is inhibited in relation to assessment at risk behaviours and safety planning.

Recommendation:

- It is recommended that parents be able to claim Medicare rebates for the purposes of assessment, psycho-education and training in parenting strategies under their child's referral and Mental Health Plan in relation to psychologists and allied health providing "focused psychological strategies".
- It is recommended that parents be able to claim Medicare rebates for the purposes of assessment, psycho-education and training in parenting strategies, and psychological therapy in relation to clinical specialist psychologists providing "psychological therapy" where indicated by a treatment plan that has been informed by a comprehensive assessment and formulation, under the Better Access program.

We wish to refer to the responses outlined by the ACPA submission (2011) for the additional terms of reference that we have not specifically addressed here, with a notable emphasis on ACPA's recommendations relating to:

> ***(e) mental health work issues including***
>
> ***(i) the two-tired Medicare rebate system for psychologists,***
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> ***(ii) workforce qualifications and training of psychologists, and***
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> ***(iii) workforce shortages.***

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