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Re: Government changes to the Better Access to Mental Health Initiative

Dear Senator Sue Boyce,
Thank you for meeting with my colleagues and me during the Science Meets Parliament program this June. I am writing to you in order to provide a submission to the Senate Community Affairs Reference Committee inquiry into Commonwealth Funding and Administration of Mental Health Services. Specifically I have concerns about the cut in the number of sessions as well as the perpetuation of the two-tiered training system which then also has an impact upon the two-tiered Medicare rebate for psychologists.

In addition to working as an academic in a clinical psychology training program, I also have a small private practice in which I see clients predominantly referred through the Better Access to Mental Health initiative. As such my views of the changes are influenced by my knowledge of the scientific evidence of psychotherapy as well as my own personal experiences as a private practitioner. In terms of the scientific literature, there is evidence that, just like medication, there is a minimum dosage of therapy required to produce clinically significant improvements in mental health. A recent Australian study found that 50% of psychotherapy clients are estimated to recover after 14 sessions and 70% require 23 sessions to fully recover from their presenting problems. As such cutting sessions to only 10 rebated sessions in a calendar year is likely to only provide bandaid assistance. There is a huge amount of literature showing the high cost of mental health problems to the community. In the long term these cuts will cost the Australian community more than it would cost to provide the necessary sessions to properly treat the mental health problems in the first instance. Just like it would not make sense to fund medication at half the required dosage, it also doesn't make sense to fund psychotherapy at dosage level that will be insufficient for a majority of people. While the mode number of sessions used per client, under the Better Access Initiative, may be less than these suggested dosage of sessions, it is likely that this may represent a range of issues other than the psychological need of the clients.

Another consideration I have is why there has been a reduction in the number of Medicare rebated sessions to psychologists but not a reduction in the number of rebated sessions to psychiatrists? There is an overlap in the types of clients seen by psychiatrists and psychologists (eg anxiety disorders and depression). Psychiatrists treat mental health problems through medication, with some psychiatrists also using the same psychotherapies as psychologists. If the reduction in sessions to psychologists is related to the issues related to psychotherapy then it does not make sense to discriminate between psychologists and psychiatrist. If the reduction in sessions to psychologists is related to psychotherapy versus medication then equally this does not make sense. There is strong evidence through meta-analyses, that the effectiveness of psychotherapy is roughly equal to that of medication for anxiety and depression, however the relapse rates are lower with psychotherapy than for medication. If this is the case then why will there

not also be a reduction in the number of sessions rebated to psychiatrists for seeing clients who are primarily depressed or anxious? This seems to be more a political decision rather than an evidence based decision, and not one aimed at aligning public policy to scientific evidence.

With regards to mental health workforce issues, an ongoing tension and challenge for the psychology profession is the two-tiered training system. This involves allowing both those who have had four years of university training plus two years of workplace supervision to be registered as psychologist in addition to those who have had at least six years of university training. International benchmarking clearly identifies Australia as an anomaly, with all other Western countries requiring at least two years of postgraduate university based training before full registration. The problem with the four plus two model is that there is very little training in clinical competencies within the first four years of most university training programs. As such the training in clinical competencies in this group is solely reliant on the workplace learning experiences they have during their two year apprenticeship. This means that in most cases, trainee psychologists are only trained in competencies relevant to one population. It also means that the quality of training is heavily dependent upon one supervisor. If they have a motivated and competent supervisor then this may be adequate (but not ideal). However if they do not have a supervisor with the time, motivation and competency to train in a broad range of skills, attributes and knowledge, then the trainee is left with deficits (of which they may be unaware). A more safe and comprehensive training model is to conduct the training through a university based postgraduate training program. This provides detailed and comprehensive coursework with practicum training with different populations and supervised typically by four different supervisors who have expertise in different areas.

The main reason for maintaining the four plus two model in Australia is fear of workforce shortage rather than concern for quality training in competency. To overcome workforce shortage concerns in the near future a significant increase in federal funding to postgraduate training programs is needed. As such it is likely that the two tiered training model will continue and will continue to divide the profession: with those who have completed the four plus two model advocating for its adequacy and those who have completed postgraduate training advocating for its advantages. Rather than base allegiance to the loyalties associated with one's own training model, a more objective approach would be to base decisions about appropriate training models upon international benchmarking and evidence based best practice.

As such I have two main recommendations:

1) Have an inquiry into the training models of psychology in Australia with an aim to develop a single training model that will not split the profession and will provide high quality training that will still meet workforce needs. This may involve comparisons with international benchmarks, as well as considering substantial new changes to the current models. For example, with greater resources more clinical training could be provided in undergraduate degrees. Another option might be to scrap the fourth (honours) year allow students to progress directly from an undergraduate degree to a postgraduate degree. It is also worth exploring the UK model where there is a closer alliance between the National Health Service and university postgraduate training programs which is closer to a hybrid of our two Australian pathways. Another option is to stop the four plus two model and then provide a significant increase in funding to current postgraduate training programs in order to increase their capacity to take more students, especially with a greater emphasis on rural and remote training. While these options have been considered by the profession before, I think that there is some advantage of having an independent inquiry with the power to make recommendations for the allocation of resources to support viable options.

2) My second recommendation is that rather than a blanket reduction in the number of rebated sessions per calendar year, a better option would be to have a stepped care plan based on matching areas of competency with the severity and complexity of the presentations. This has been attempted in the current model, but could be developed further in order to provide more cost effective and targeted interventions. The introduction of the Endorsed Areas of Practice within the new national Psychology Board of Australia provides an easy and sound way of doing this. That is, those who have been accepted into an Endorsed Area of Practice have had a peer review approval of expertise within the profession. It would therefore make sense to direct more complex cases to those with accepted expertise.

   In this model GPs would conduct the initial assessment and based upon their assessment refer clients to

a) Approved online resources for transient mild cases that do not meet the requirements for a mental disorder.
b) Non-Endorsed psychologists to see mild mental disorders (such as adjustment disorder) with a cap of 10 sessions per calendar year at current reimbursement levels.
c) Endorsed psychologists to see designated moderate to severe cases (such as Major Depressive Disorder and anxiety disorders) with a cap of 20 sessions per calendar year at current reimbursement levels.
d) Psychiatrists to see designated moderate to severe cases (such as Major Depressive Disorder and anxiety disorders) with a cap of 20 sessions per calendar year at current reimbursement levels.
e) Psychiatrists to see designated severe cases (such as personality disorders and psychosis) with a cap of 50 sessions per calendar year at current reimbursement levels.

I hope that these considerations prove helpful in the inquiry and I am happy to provide further elaborations on anything that you may find helpful.

Yours sincerely,

Dr Esben Strodl