Committee Secretary 23-07-11
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600
Australia

Dear Committee Secretary,

RE: Senate inquiry on the Commonwealth Funding and Administration of Mental Health Services

I have been a practicing clinical psychologist for the past 5 years. I completed my undergraduate degree at La Trobe University, Melbourne. I also completed my Doctor of Clinical Psychology at La Trobe University. This training took a total of 8 years full time study. Since this time I have worked in a range of settings, including public mental health, academic research, and community corrections. I currently work in private practice.

I would like to express my severe concern at 1) The proposal to limit access to psychological sessions to 10 per calendar year, and 2) The call from Medicare providers with only basic training to abolish the difference in the Medicare rebate between those having generalist qualifications and those having advanced clinical training in the delivery of mental health interventions (i.e., clinical psychologists). I would therefore like to address the following terms of reference for the senate inquiry.

Term of Reference (b 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*

Whilst new investments in mental health care are important and are to be applauded, I am deeply troubled that they are at the detriment of existing mental health programs. It seems a case of "Robbing Peter to pay Paul". The capping of sessions to ten, effectively targets the most vulnerable minority for exclusion from the services they require. These people are typically less able to afford sessions without the assistance of Medicare, and are not severe enough to meet admission criteria to a public mental health service. It remains to be seen how well their needs will be met under the proposed ATAPS program. I would like to make some more specific points below:

1. **Factoring in for Crisis and Risk**

A cap of 10 sessions does not factor in crisis situations and clinical risk. Simply because a client is classified as mild – moderate, does not exclude them from suicidality and other forms of self-harm. If one has ever had contact with a Crisis Assessment and Treatment Team (CATT) at a public mental health service, it becomes easy to understand how difficult this service is to access (simply because they are under-resourced).

I have had 2 occasions this year where I have had clients in acute crisis with an

active suicide plan and intent to follow-through on this plan. On one occasion, they were told by CATT that they did not qualify for a home crisis assessment visit. On yet another after hours crisis, the client simply refused to attend the emergency department of a public hospital. I was required to spend considerable time on the phone with them (late at night), and consulted them the next day. What am I to do with such clients if I have had 9 sessions with them? Simply send them home and ask them to come back next year? Send them to a psychiatrist with a minimum 1 month waiting list? Send them back to their GP for a 15 minute consultation? The government has a duty of care to Australians to ensure that have access to quality mental health services in such times of crisis. Working through such crisis can take 6 sessions in and of itself, leaving only 4 sessions to work on the issues that created the crisis to begin with. This makes little logical sense.

2. **Making clients independent of therapy and prevention of relapse**

The goal of any clinical psychologist should be to "do themselves out of a job with their client". That is, the clinical psychologist's job is to provide the client with the skills and tools necessary to deal with their emotional or behavioural problems independently. It is not in my best interests, or the client's best interests, to stay in therapy indefinitely. Thus I agree that there needs to be some cap on the number of sessions available per calendar year. Yet a cap of 10 is not in line with the mountain of evidence suggesting that high prevalence mental health issues (e.g, major depressive disorder, generalized anxiety disorder, panic disorder) require between 12-24 sessions of treatment. The provision of more sessions allows a client to learn a more comprehensive set of skills, thus decreasing their risk of relapse, thus decreasing their need to access services again in the future (i.e., the revolving door).

3. **Access to Psychiatrists**

I note that the government made reference that consumers of the better access service can access the services of a consultant psychiatrist should they run out of sessions with a clinical psychologist (or of course in the place of clinical psychology services). This is an ill founded idea. While I have a deep respect for consultant psychiatrists (and the significant and unique role they play in mental health care), if one has ever been on a waiting list to see a psychiatrist, one would understand that it can be between a 2-6 month wait. The out of pocket expense can also be significant, and indeed, prohibitive. Clinical psychology services are cheaper, more accessible, and proven to save money via decreasing disability, increasing functioning, and keeping people out of hospital. Clinical psychologists can not provide the most effective service possible while burdened by a restrictive 10 session model.

4. **A clients perspective**

A case example may be useful here. I recently had a young teenage girl attend for recurrent panic attacks. I diagnosed her with Panic Disorder with agoraphobia. After 7 sessions, she was showing only minimal treatment gains using exposure and cognitive therapy. On the 8th sessions, she revealed to me that 1) her mother was abusing IV drugs, and 2) she was being sexually abused by a family member. What am I to do with this young girl if our sessions were

capped at 10? How may this young girl feel after she has entrusted me with this information only to have to finish seeing me in our next session? How am I to coordinate an appropriate intervention for this young girl that addresses all the complexities of her situation? This is not an isolated situation, and I could list dozens similar over the past 5 years.

The vast majority of my clients have expressed deep concern about these cuts, which is reflective of the value that they place on psychological services.

Term of Reference (e i): The two-tiered Medicare rebate system for psychologists

The points below are designed to elucidate a rationale to maintain the current superior rebate for clinical psychology services ($120) compared to general psychology services ($80). The argument is not that clinical psychologist are superior to general psychologists. The argument is that clinical psychologists have been specifically trained to directly meet the mental health care needs of consumers, according to how these consumer needs have been defined under the Better Access system. In short, clinical psychologists have been specifically trained to assess, diagnose, and treat mental disorders. This is the precise purpose of the Medicare psychology items. No other psychologist can claim this specialisation.

1. **Differences in training between clinical psychologists and general psychologists**

   Below I cover the two standard training models to become a generalist psychologist

   a. *Four plus Two Model to becoming a generalist psychologist*

The four plus two model of training to become a psychologist involves completing an undergraduate degree in general psychology (e.g., Bachelor of psychology) and then 2 years of supervised experience under a fully registered psychologist. There is no post-graduate education involved in this training model.

An analysis of an undergraduate psychology program will reveal that there is not a single subject specifically dedicated to learning the skills to assess, diagnose, and treat mental health issues. Some subjects will provide a basic overview of assessment, diagnosis, and treatment, yet none actually teach these basic skills. Those students who do not obtain the academic results to gain entry to a specialist postgraduate program rely on 2 years of supervision from another psychologist to teach them these skills. The flaws of this model are well established. The student is entirely reliant on the individual psychologist to teach them the requisite skills to assess, diagnose, and treat mental health issues. Compare this to a post-graduate student, who undergoes a minimum 2 years within an accredited University, consisting of lectures, tutorials, extensive clinical placements (under supervision), as well as completing a masters or doctoral research thesis that is reviewed by local and international experts.

It is also notable that modern industrialised countries such as the United States and the United Kingdom mandate post-graduate training to become

registered as a psychologist.

Only a small minority of undergraduate students will obtain entry into post-graduate psychology programs. Only the most academically competent students gain entry into these specialist postgraduate programs (acceptance into these programs is based almost entirely on academic performance). These specialist programs provide skills that are infinitely superior to those obtained by a generalist psychologist under the 4 plus 2 model. Those with the highest levels of training should have services rebated at a higher level as a reflection of the time, effort, and academic competence required to achieve a masters or doctoral degree.

b. Post-Graduate Training in other specialist areas (e.g., counseling psychology, educational psychology) to become a generalist psychologist

There are psychologists who achieve entry into other specialist postgraduate programs (e.g., masters in counseling or neuropsychology). These psychologists make a choice to study in this specialist area of psychology, with each course having a different focus of training. I would like to note that I have a strong respect for all specialist areas of psychology. Yet the entire function of specialization is to create a workforce with different skills to apply to different areas. If there were specialist items for counseling or neuropsychology (for example) services that were exclusively relevant to their skills and expertise, I would happily and humbly allow myself to be classified as a "general psychologist" for those items. One must know both the strengths and limitations of one's skill base.

To illustrate the issue of specialization, I have listed the coursework subjects for a clinical versus counseling masters at La Trobe University below:

Clinical Psychology – Masters by Coursework Subjects (La Trobe University)

1. Cognitive-Behavioural Theory, Assessment and Practice
2. Counselling Skills and Professional Issues
3. Psychological Assessment
4. Clinical Assessment and Treatment
5. Clinical Treatment Literature
6. Psychopathology (Adult and Elderly)
7. Methods for the Scientist Practitioner
8. Child and Adolescent Disorders
9. Context and Co-morbidity in Clinical Practice

Counselling Psychology – Masters by Coursework Subjects (La Trobe University)

1. Individual Counselling Psychology A
2. Individual Counselling Pychology B
3. Psychological Assessment
4. Group Counselling Processes
5. Child and Family Psychology

It is apparent that the clinical psychology program takes a more specific focus

on training in the "bread and butter" of the Medicare Better Access Items – the assessment, diagnosis, and treatment of mental illness. Although a counseling psychology masters no doubt covers the assessment, diagnosis, and treatment of psychopathology, it is clear that this is not the **singular** focus of the course. There are clear differences between these two courses in the **DEPTH** and **BREADTH** of focus on psychopathology (again, the core target of the Better Access Program).

Several of the models (e.g. Psycho-Analytic Psychotherapy) that are taught in the post-graduate training in other specialist areas of psychology are not actually covered under the Medicare items. In contrast, only evidence based treatments that are covered under Medicare Items (ie., cognitive behavioural therapy, interpersonal therapy) are taught in post-graduate clinical psychology courses.

There is a college of clinical psychologists and a college of counseling psychologists (for example) for a reason – they are both distinct and both have different skills and expertise. If this was not the case, there would be no point in having separate colleges or titles. Only clinical psychologists can claim to have training that exclusively focuses on the assessment, diagnosis, and treatment of mental health issues. I warmly welcome any psychologists with the requisite motivation to complete further training in order to gain admission to the clinical college.

2. The Purpose of the Better Access Initiative

The entire purpose of The Better Access Initiative is to treat mental health issues. Only clinical psychologists have postgraduate training that is specifically designed to treat mental health issues. No other specialist area of psychology can claim this.

3. International Trends

The specialist nature of clinical psychology is well recognized within US and UK health systems. Clinical psychologists have a specialist title, and the unique contribution of their work is recognized by the higher remuneration they receive in these health systems. Counselling psychologists, neuropsychologists, and other psychology specialists are not recognized as mental health specialists under these jurisdictions. Reducing the rebate for clinical psychology services would completely contradict these international trends.

4. The "Experience Counts" Argument

Some general psychologists will argue that their "years of on the job work experience" provides them with the specialist skills they need to treat mental health issues effectively. This argument draws into question the utility of the post-graduate training process, and at the same time, the venerable tradition of post-graduate study that has been a cornerstone of the education system since universities in medieval Europe, or even further back to ancient Greece. What would be the point of having postgraduate programs at all if they offer no benefits above and beyond what practical experience can afford?

5. Supply and Demand

The principle of supply and demand is relevant to the specialization issue. There are less clinical psychologists, meaning there is less supply. There is also a clear demand for clinical psychology services (as indicated in the number of clinical psychology services used). In fact, there are more clinical psychology services claimed in Western Australia than general psychology services. In cases where there is less supply and more demand, prices increase. The most basic principle of economics (supply and demand) would support a higher rebate for clinical psychology services.

6. Direct effects on clients

Reducing the rebate would make bulk billing in my practice impossible, given that a rebate of $80 would barely cover rent and other expenses. I currently bulk bill 30% of my patients, very few of who could afford any out of pocket expense. What would become of these clients?

Of those clients who do pay an out of pocket cost, many would not be able to incur a larger out of pocket cost. The entire point of the Better Access Initiative is to provide "Better Access" to the best psychological services. Cutting the rebate makes access even more difficult, directly contradicting the very name of the program.

7. Dilution of the Clinical Psychology Workforce

Without recognition (through extra remuneration), our best and brightest undergraduate students (and future psychologists) have little motivation to undergo specialist clinical psychology postgraduate training. What would be the point of taking the time, effort, and cost of completing postgraduate training if there was no incentive (via professional recognition and remuneration) to do so?

8. Do we want a health system that encourages/demands the highest level of training for its service providers?

Reducing the rebate for clinical psychology services would be a clear backward step in terms of providing the most highly trained and specialized workforce for the treatment of mental health issues in the Australian Community. If one was to put themselves in the shoes of a client suffering from a mental health condition, would one want to be treated by a person with a minimum masters level qualification specifically in treating mental health problems, OR treated by a person with no post-graduate training whatsoever (the 4 + 2 model), or training in another area of psychology that does not exclusively specialize in the mental health issue they are seeking treatment for?

9. The recent empirical evaluation of the Better Access Initiative

Some general psychologists have argued that the recent evaluation provides support for the abolishment of the two tier system. 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; it did not identify the nature or type of psychological intervention actually provided; it did not factor in or out medication use by the client; it did not factor in or out therapy adherence indicators; 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; 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; it did not determine relapse rates by type of psychologist; it was a self-selected sample of psychologists who self-selected their clients and clinically administered the research questions in session; it was not subjected to peer review). General psychologists claiming that this study is "proof" that there is no difference between the quality of services provided by general and clinical psychologists are merely reflecting a lack of comprehension for empirical methodologies, which would be consistent with a lack of training in this area.

10. The Rule of Common Sense

Common sense indicates that those with the highest level of training in a given area will have the highest level of skill in that area. If this were not the case, we may be best to scrap the entire tertiary and other specialist education systems. Clinical psychologists have the highest level of training in mental health, and thus, using the rule of common sense, have the highest level of skill.

11. The Public Mental Health System

Membership to the College of Clinical Psychologists has long been a common pre-requisite of obtaining employment in a public mental health service. These public mental health services specialize in the provision of assessment, diagnosis, and treatment of mental health issues. This is recognition of the specialist skills that clinical psychologist's posses in mental health care.

12. Clinical Psychologists Save Money

I note that the government made reference to consumers of the better access service can access the services of a consultant psychiatrist should they run out of sessions with a clinical psychologist. This is an ill founded idea. While I have a deep respect for consultant psychiatrists, if one has ever been on a waiting list to see a psychiatrist, one would understand that it can be between a 2-6 month wait. The out of pocket expense can also be significant, and indeed, prohibitive. Clinical psychology services are cheaper, more accessible, and proven to save money via decreasing disability, increasing functioning, and keeping people out of hospital.

13. The issue of co-morbidity

It is well established that co-morbidity (i.e., two or more conditions [e.g., alcohol abuse and depression] occurring together) is very prevalent in primary care settings. Only clinical psychologist receive the specialist training to effectively prioritise and treat such co-morbidities, and create realistic

treatment targets within a 12-18 session model.

14. The Ethical Principle of Non-Maleficence (i.e., do no harm)

It is well established that the misuse of psychological interventions can harm clients. Clinical psychologists have the most extensive training in the provision of mental health treatments, and the contraindications of such treatments. Without such specialist training, one is left in a grossly inadequate position to have the depth of knowledge required to understand these nuances.

15. Precedents from other Health Professions

A cornerstone of the medical profession is specialization. Doctors complete specialist training in their chosen area (e.g., dermatology, orthopedic surgery, cardiology). Just as psychologists (who obtain sufficient academic results to obtain entry into a post-graduate program) choose to specialize in a given area of psychology (e.g., clinical, forensic, counseling, neuropsychology). Would we ask a cardiothoracic surgeon to complete knee replacement surgery typically completed by an orthopedic surgeon? We have specialization for a reason - to ensure that the most highly trained people in a given area perform the work in that area to obtain the best possible results.

Concluding Comments:

The Better Access Scheme has opened up unprecedented opportunities for Australians to access affordable mental health care. However, if services are to be cut, then this cut should apply to providers with the least amount of training and expertise in the core business of the Better .Access Initiative (the assessment, diagnosis, and treatment of mental disorders). Thus access to Clinical Psychologists via Medicare should not be changed, since this group of providers is specifically trained to meet the mental health needs of consumers as defined by the Better Access Program.

Not all service providers are the same, and the level of rebate applied to items should be reflective of the levels of skill, competence, education, and specialization held by that provider. This common sense point is applied to other Medicare items for specialists in other health areas, and should also be for clinical psychology items.

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Thank you for kindly taking the time to consider this submission.

Kind Regards

Dr David R Collins
Clinical Psychologist