Commonwealth Funding and Administration of Mental Health Services

Senate Inquiry: Community Affairs References Committee

We are three clinical psychologists in private practice in a rural community in NSW. We are not going to address all of the terms of reference, but would like to state that we have read draft submissions prepared by the Clinical College of the Australian Psychological Society (APS), the Australian Clinical Psychologists Association (ACPA), and the Australian and New Zealand Academy of Eating Disorders. We support these submissions. Rather than address all the TORs, the concerns included herein specifically relate to:

(b) (ii)The rationalisation of allied health treatment sessions

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

(b) (iv) the impact of changes to the number of allied health treatment services for patients with mild or moderate mental illness under the Medicare Benefits Schedule

(e) (i) The two-tiered Medicare rebate system for psychologists

(e) (ii) workforce qualifications and training of psychologists

(h) 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

In Brief

Many of our patients/clients are GP referred and have ***complex*** presentations with severe levels of symptoms. We treat our clients under MBS items such as 80010. We are concerned that if the proposed changes are enacted we will most likely close our practice for people with severe disorders because we will be unable to provide the level of care needed to work with our patient group in 6-10 sessions. Many of our patients require 12+ sessions and many people are unable to afford our treatment without access to Medicare rebated sessions.

Also, should the tiers be collapsed, we believe our specialist training (which we and the rest of the Western world regard as being necessary to do our job adequately) would not be recognised or utilised, and if this were the case we would feel so disenchanted and dispirited that we could seriously entertain the thought of giving up our profession (i.e. clinical psychology). It is important to note that one of our practice members conducted a successful private practice prior to the implementation of the Better Access to Mental Health Scheme by the Howard government, and she knows that she could continue to operate a financially viable practice. However, the nature of the practice would significantly change because it would be unethical to take on people with serious

problems and then abandon them mid-treatment after 6-10 treatment sessions. That is, the three of us would work with fewer people with serious mental health issues and this would reduce access to appropriate mental health services for people 4-90 years of age who cannot afford private sessions.

Submission

(b) (ii)The rationalisation of allied health treatment sessions i.e. mild to moderate levels of severity

The current two-tiered system attempts to recognise the different training and skills of psychologists and clinical psychologists. It also recognises ***the different level of need between people referred with uncomplicated presentations and those with more complex presentations, the latter requiring a specialist to assess, diagnose and tailor treatment.*** Unfortunately, many general practitioners don't appear to understand the difference between psychologists and clinical psychologists and they do not seem aware of the different item numbers that psychologists and clinical psychologists use. We are often told by our patients that their general practitioner simply handed them a Division of General Practice list of all local psychologists. The list does not differentiate between clinical and non-clinical psychologists. Often, the only differentiating information on the list of psychologists is the fee.

We think that it's important to maintain the two-tiered system but improve it. For instance, there could be a clearer delineation between the generic services provided by a 4+2 psychologist and those specialist services provided by a 7 + 2 clinical psychologist. Delineation could occur on the basis of factors such as ***complexity.*** Factors increasing the complexity of the mental health illness include co-morbidities, chronicity, and the nature of the illness itself e.g. a person with an eating disorder such as Anorexia Nervosa may also be depressed, anxious or have drug and alcohol problems in addition to personality disorder/s. Unlike many mental health illnesses an eating disorder illness is usually ego-syntonic, meaning the person is reluctant to change restrictive eating because eating healthily is frightening. This means that treatment is more complex and protracted because motivation to change is low. On the other hand, the same person may be motivated to reduce the depression symptoms (depression is ego dystonic), but they are unlikely to successfully reduce depression symptoms under a regime of semi-starvation.

Currently, it seems poorly understood that clinical psychologists are best suited to provide diagnostic and tailored treatment for people with complex and/or moderate to severe levels of mental illness (e.g. items 80100 v's 80010).

Recommendation: General practitioners need to be educated about the difference in services and associated item numbers. The two-tier system needs to be strengthened to retain and continue to attract appropriately trained clinical psychologists.

Recommendation: Clinical psychologists are better trained than GPs in the process of assessment and diagnosis of mental health problems, and therefore there could be some sort of rationalization that enables clinical psychologists to develop the mental health treatment plans.

(e) (i) The two-tiered Medicare rebate system for psychologists

There are some psychologists who argue that there is no evidence that clinical psychologists do a better job than 4 + 2's and they refer to the Better Access evaluation conducted in 2010. One of us participated in the Better Access evaluation of mental health services and found the experience concerning and frustrating because of the inadequate nature of the design of the evaluation. Very little information could be given regarding the diagnoses; the measurement instruments were not matched with diagnoses (it sometimes felt like being forced to take blood even though we knew we were meant to be assessing a fracture); participants with severe levels of distress and disability did not participate in the research because they typically chose not to (e.g. they felt uncomfortable/paranoid about providing the government with information); other variables such as GP involvement, medication, co-morbidity, previous mental health involvement (not just plans) and so on were not considered The fee paid per session was required, but there was no where to explain what that fee included.

Another concern was that the study did not differentiate between referral questions and tasks. For the 4 + 2 psychologists, the GP referral (2710) is not for assessment, diagnosis and psychological therapy tailored to meet the individual's presentation. The referral is simply for focused psychological services (CBT) for a GP diagnosed illness. In contrast referrals to a clinical psychologist typically ask for ***assessment, diagnosis and treatment***; the process is more clinical and typically, the patient's presentation is more complex and requires assessment and treatment other than focused psychological strategies e.g. an assessment may reveal a complex presentation such as a combination of spinal compression fractures/osteoporosis, chronic pain and associated opiate dependence, catheterisation, high levels of suicidality/self harm, agoraphobia, relationship problems and a chronic disease for which treatment has rendered the person clinically blind, all on a background of childhood neglect.

As mentioned in a previous section, the Better Access tests used to measure change (i.e. the DASS 21 and K10) are very blunt instruments and it is inappropriate to use them to measure change with many of the patients who participated in the study e.g. patients with Anorexia or Bulimia Nervosa. Whilst a patient is able to restrict their eating and over exercise their depression, anxiety and stress scores on the DASS 21 may be mild to moderate; once treatment begins and these ego-syntonic behaviours are replaced with healthy eating and limited or no exercise anxiety, depression and stress symptoms may increase until much later in the recovery process. For these patients, recovery may take over 18 sessions per year because the illness can take many years to treat.

Recommendation: It is our strong opinion that the two-tiered Medicare rebate system needs to be retained but strengthened as it recognises the value of accredited post-graduate training and specialisation in clinical psychology. We are concerned about the apparent ignorance of the value of post-graduate clinical training by those who do not hold these qualifications, those who represent them and/or those who refer to psychologists and clinical psychologists.

Recommendation: It is also our strong opinion that the 6 + 4 session allocation will be inadequate to treat most of our clients because they typically present with complex problems that require more

than focused psychological strategies. We recommend that clinical psychologists be able to treat patients with complex problems for up to 20 sessions.

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

We don't think that GPs currently understand the two-tiered system, and therefore recommend that they be educated so that they make appropriate referrals.

(b) (iv) the impact of changes to the number of allied health treatment services for patients with mild or moderate mental illness under the Medicare Benefits Schedule

Our concern is that the proposed changes will redirect monies away from our rural community as a whole in order to focus on age-specific services that are targeted to 16-25year olds situated in regions large enough to receive a Headspace Centre. Taking away well utilised and highly valued services will produce a hole in service delivery and disadvantage our whole community.

Currently, in our private practice, we provide clinical psychology services to a wide range of patients, including children, adolescents, adults and older age people. Our practice is situated in a rural community, and because of the small population base we cater for a wide range of people. The proposed changes will reduce access to mental health services, limit what we can offer and for how long and not replace it with anything in our community. That is, the money will go to bigger communities that have been allocated a Head Space centre and the money will focus on 16-25 year olds. This means that the services that we currently offer to 4-90 years olds in our community will be significantly reduced because funds have been focused on a more limited program that will not reach small rural communities.

Recommendation: Rather than cutting the current allowance of up to 18 sessions in exceptional circumstances we strongly recommend that clinical psychologists under the five MBS items (80000, 80005, 80010, 80015, 80020) that are allocated for the provision of psychological therapy services to eligible patients by a clinical psychologist be extended to 20 sessions.

(e) (ii) workforce qualifications and training of psychologists

One of our three practitioners initially trained as a school counsellor (educational psychologist) prior to training as a clinical psychologist. She had an undergraduate degree in Psychology and the equivalent of an Honours degree [titled an M Psych (Ed)] from Newcastle University. Until she undertook her additional three years of clinical training she DID NOT KNOW WHAT SHE DID NOT KNOW! With hind sight and to put it bluntly, she admits she was often ignorant.

This clinical psychologist used 20 years of superannuation to undertake additional training and in doing so forewent three years of income. Ethically, she is very glad that she undertook the training but it has not been a sensible business decision because she could have continued practicing without the knowledge that she now has, and she would have continued to ***not know what she did not know***, but she would now be better off financially. If proposed changes are adopted (i.e. the collapsing of the two tiers) the Federal government will be financially reinforcing and advocating for

sub-standard training and financially rewarding those who chose not to undertake adequate training.

It is important to note that no other country in the Western World allows people to practice as psychologists with an undergraduate degree plus one additional year of study followed by supervision (i.e. 4 + 2). Australian standards are comparably and notably poor. The clinical psychologist who previously practiced as a 4+2 for almost 20 years now views her pre-clinical training work as having been amateurish compared with the level of skill, knowledge and service that she is now able to deliver, given her subsequent efforts to undertake adequate training. She now believes that her clients are in good hands. She is now a 7 + 2, as opposed to a 4 + 2. She has had daily clinical supervision in hospitals and outpatient specialist settings over the three years of post graduate training. She has been trained to work with psychiatrists and other mental health professionals to provide team care for people with severe mental health problems.

Recommendations: Given the level of training that a clinical psychologist undertakes, we recommend that a separate register of qualified clinical psychologists is established to enable the public and GPs to identify those clinical psychologists with the qualifications that meet the minimum standards set down by the Psychology Board of Australia.

Recommendation: We also recommend that all psychologists working in mental health receive postgraduate clinical training. Standards have changed as more scientific research has been conducted and the training practices that used to be acceptable are no longer adequate or acceptable in an increasingly modern world.

(h) 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

Two of us have experience with the CRUFAD online sessions (provided out of UNSW) but have found that our 25 CRUFAD-referred clients prefer the opportunity for face-to-face treatment and there has been a high rate of treatment drop out on purely internet based programs with our clients. Also, many of our clients have highly complex presentations and these generic programs are not suitably tailored for our clients.

Recommendation: On line services may be an option for some people with mild-moderate symptom severity but it is not an adequate replacement for complex clinical work that we currently deliver to our clients.

Some of our clients travel up to 4 hours one way to access our services and many of these people often ask if we can conduct some of the sessions via SKYPE or telephone. Currently we are unable to do this because of the Medicare regulations; however, it would be helpful to our clients if we could conduct some sessions via SKYPE or telephone. People who travel long distances have higher session postponements and come less frequently than optimal because of the difficulties associated with long distance travel when feeling unwell, and also, the additional costs.

Recommendation: We strongly recommend that some of the mid treatment sessions be conducted through telecommunication in order to maximise treatment outcomes for people in more isolated areas.

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Add a Medicare item to provide for other family members to be seen in joint or separate sessions.