25 July 2011

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

Email: community.affairs.sen@aph.gov.au

Dear Committee,

COMMONWEALTH FUNDING AND ADMINISTRATION OF MENTAL HEALTH SERVICES

I wish to express my concern in relation to the above. Specifically:

1. Proposed removal of the two-tiered Medicare rebate system for psychologists, resulting in equal recognition of general trained psychologists and psychologists who have completed a clinical masters degree.

I am a clinical psychologist in private practice in Sydney. As well as providing therapy to clients, I hire, supervise and train other psychologists. My chief concern regarding removal of the two-tiered system is that it is misleading to clients of psychologists, and has the potential to cause harm and increase costs to the community in the following ways:

A four year psychology degree (undergraduate degree followed by an honours year) provides minimal or no formal training in working with clients

The first four years of psychology training focus on conducting and evaluating research, and on theoretical rather than practical knowledge. The scope of the subject matter is very broad and much of it is not directly relevant to clinical practice except in that it teaches students to think scientifically and to critically evaluate research. These years do not equip students to be practitioners. Rather they provide students with the "scientist" component to the "scientist-practitioner" model, and lay the foundations for further vocationally oriented study.

Downgrading the recognition for postgraduate training would put Australia out of step with Britain, Canada, the UK and USA, where a minimum of six years formal study is required for a psychologist to practice.

A clinical masters or doctorate degree is the only degree in psychology in which complete post graduate training is in the area of mental health

As outlined by the APS College of Clinical Psychologists, and others in their submissions, clinical psychology is one of nine equal specialisations within psychology (e.g. neuropsychology, health, forensic, family and relationship counselling, community, exercise and sport, education and developmental, and organisational). I reiterate others' submissions that all specialisations are equal but not the same. Other than psychiatry, clinical psychology is the only profession whose complete post-graduate training is in the area of mental health.

The areas of specialisation in psychology are internationally recognized. The American Psychological Association (APA) notes that "A specialty is a defined area of psychological practice which requires advanced knowledge and skills acquired through an *organized sequence of education and training*. The advanced knowledge and skills specific to a specialty are obtained *subsequent to the acquisition of core scientific and professional foundations in psychology*" (http://www.apa.org/about/governance/council/policy/principles-recognition.pdf).

With respect to clinical psychology the APA notes that "What distinguishes Clinical Psychology as a general practice specialty is the breadth of problems addressed and of populations served. Clinical Psychology, in research, education, training and practice, focuses on individual differences, abnormal behavior, and mental disorders and their prevention" (http://www.apa.org/ed/graduate/specialize/clinical.aspx).

As the Medicare rebate offered under the Better Access to Mental Health initiative relates to Mental Health conditions / disorders, the psychologists who are specifically and comprehensively trained to provide these services are clinical psychologists.

Following four years of training, it is not possible to impart the material covered in a master's degree during on-the-job training and supervision

As a supervisor, I am keenly aware that it is impossible to impart even a small fraction of the material covered in a clinical masters degree to supervisees, even when supervision is held on a daily basis, which it typically is not. The fact that a supervisee contends with a caseload of clients and the demands of employment means that they have neither the time nor the resources to undertake reading and learning comparable to that of a postgraduate degree. Similarly, a supervisor with a job of their own cannot double as a department of university lecturers and provide comparable educational material and evaluation of learning.

Moreover, without postgraduate clinical training, supervisees do not have the concepts or language to discuss clients with their supervisors in a way that enables their clinical learning. For instance, a supervisee who is not aware of the concept of hypomania, or does not know how to assess for it, is very likely to miss symptoms of hypomania in a client. Consequently, such a supervisee will not mention to their supervisor any of the hypomanic symptoms that would prompt a necessary discussion of hypomania and Bipolar II Disorder essential to that supervisee's learning.

Harm can be done the client in the process, as they are never adequately diagnosed and treated. I submit that this is not a rare occurrence. For example, it is estimated that 80% of Bipolar clients go undiagnosed and hence untreated for an average of 10 years (Black Dog Institute, 2010). This carries a great cost to the individual and the community.

For instance, according to a Black Dog Institute factsheet: "the financial costs of bipolar disorder to the Australian community amount to $1.59 billion per annum through inability to function at home and in the workplace; of all Australians with bipolar disorder, only one-third receive treatment; on average, 69% of people with bipolar disorder are misdiagnosed 3.5 times; on average, it takes 10.2 years and 4 doctors to obtain a correct diagnosis of bipolar disorder" (http://www.blackdoginstitute.org.au/docs/FactsandFiguresfactsheet.pdf).

This is one example of the false economy involved in decreasing clients' access to the mental health professionals who are specifically trained to treat them.

The learning that occurs during on-the-job supervision and training is widely variable and unregulated

The quality of a supervisee's on-the-job learning depends on the supervisee's willingness and ability to learn, the supervisor's knowledge and skill, and the learning opportunities afforded by the work context. Each of these factors has an extremely wide margin of variability, with accordingly wide variability in the psychologist's ultimate skill level and knowledge base. For an issue as important as mental health, it is reckless to afford this pathway the same standing as an accredited educational benchmark.

Harm can unwittingly be done to clients with mental health disorders when treated by health professionals without training in the diagnosis and treatment of psychological disorders

Aside from overlooking diagnoses and failing to offer appropriate treatment, practitioners without specific mental health training are not aware of what they do not know, and may believe that they are equipped to treat a particular condition, when in fact their approach may exacerbate and maintain that condition. For example, when a client with anorexia begins eating again, a re-feeding syndrome involving metabolic disturbances may occur, which can be fatal if not carefully medically monitored. A generalist practitioner may not be aware of such risks when working with an eating disordered client.

As another example, one of the mechanisms of Generalised Anxiety Disorder is avoidance of negative emotions and negative thoughts. Although it may seem prudent to use standard anxiety management techniques with such clients, if not used carefully in the context of particular psychoeducation, such techniques may be employed as a further form of emotional avoidance by the client, potentially maintaining and exacerbating the disorder rather than treating it. Similar iatrogenic effects can occur with Panic Disorder. Many times in my practice I have seen clients who have suffered unnecessarily with Panic Disorder for years or decades, repeatedly seeking ineffective treatments from practitioners who were not trained to recognize and treat Panic Disorder effectively. I have seen clients whose simple Panic Disorder has progressed to Posttraumatic Stress Disorder as they have been repeatedly traumatized by panic attacks that they did not understand, as their disorder was never accurately diagnosed and explained to them.

Aside from the suffering caused, this increases the cost to the community in the long term as disability due to the untreated disorder is exacerbated, and treatment-seeking is prolonged. Indeed, many evidence-based treatments for specific disorders involve counterintuitive elements, which would not be attempted by a practitioner operating from the perspective of general counselling rather than disorder-specific, or formulation-specific, treatment.

Effective evidence based focused psychological strategies for mental health disorders need to be carefully matched to each client's presentation to be effective

Medicare approved focussed psychological strategies involve a large array of potential specific strategies and particular variants of cognitive behaviour therapy. To be maximally effective, these strategies need to be matched not only with a particular client's psychological disorder but, more importantly, with the specific factors causing, exacerbating and maintaining that disorder for that client. Clinical psychologists are trained to understand and assess the complex interplay of psychological mechanisms driving mental health disorders, to create individualized "formulations" of such causal drivers for each client, and to tailor treatment in a way that matches treatment strategy to each client's formulation. Moreover, clinical psychologists are trained to be aware of how knowledge of formulations and treatment strategies is evolving with respect to each disorder, and how to remain abreast of developments as they arise, which they continually do.

Psychologists have a responsibility to be well educated and well informed

A genuinely informed psychologist, whatever their area of specialization, never feels that they know it all. On the contrary, they are aware of the complexity with which they work, and the ever-present potential to know more. Psychology is a discipline with an enormous body of rapidly expanding knowledge, and the public requires practitioners who are dedicated to remaining as informed as they can be. I urge the committee to be skeptical of any argument that attempts to paper over this breadth and complexity and the responsibility that it carries.

To make arguments about Medicare funding on the basis of one study reflects a misunderstanding of the process of scientific research and its appropriate interpretation

I note that the AAPi cite a piece of research undertaken by Medicare to support the position that there are no differences between 4 year trained generalist psychologists and clinical psychologists. As raised by the National College of Clinical Psychologists and by others in their submissions, this research suffers from methodological weaknesses, documented elsewhere.

Further, regardless of its methodological status, one study is not a valid basis on which to draw conclusions or define policy. All psychologists (generalists and specialists alike) with training in conducting and evaluating research know that research outcomes only acquire the status of knowledge

when there is a convergence of evidence across a range of studies, conducted by different researchers with different samples, each study addressing the methodological limitations of previous studies. To make arguments about Medicare funding on the basis of one study alone reflects a misunderstanding of the process of scientific research and its appropriate interpretation.

My other concern is that:

2. The number of sessions available to clients has been reduced from 18 (exceptional circumstances) or 12 (normal circumstances) to 10 sessions per year.

Many clients with mental health conditions require significantly more than 10 sessions per year

In a literature review, Hansen (2002) notes that "there is general consensus that between 13 and 18 sessions of therapy are required for 50% of patients to improve. Reviewing the clinical trials literature reveals that in carefully controlled and implemented treatments, between 57.6% and 67.2% of patients improve within an average of 12.7 sessions. Using naturalistic data, however, revealed that the average number of sessions received in a national database of over 6,000 patients was less than five. The rate of improvement in this sample was only about 20%. These results suggest that patients, on average, do not get adequate exposure to psychotherapy" (p. 329).

Similarly, in a recent Australian Study of 125 clients receiving treatment for psychological disorders, Harnett, O'Donovan, & Lambert (2010) note that "Recovery took more treatment, with 50% of clients estimated to recover after 14 sessions and 70% requiring 23. On the basis of the present results we conclude that the present policy of the Australian Government in both the public and private sector regarding the number of sessions needed for clients entering psychological treatments to show a benefit is much less than is, in fact, necessary. The findings of the current study are roughly consistent with those found elsewhere and suggest a minimum benefit should be closer to 20 sessions. The current policy appears to be suitable for only about one-third of clients who carry the burden of psychological illness." (p. 39)

Many clients are not in a position to afford the extra sessions that they need outside of Medicare-rebated allocation. In these instances, there are insufficient services currently available for a disadvantaged and vulnerable group that will be unable to afford their treatment.

By limiting the number of Medicare rebated sessions to 10, the government is misleading mental health care consumers and undermining therapy effectiveness

It is not unusual, under the current entitlement of 6 + 6 Medicare sessions, that clients internalize those numbers as the "norm", and believe that if they cannot recover in either 6 or 12 sessions, that they are untreatable. Such hopelessness is counterproductive not only for the client's psychological health, but for their responsiveness to treatment. Self efficacy, hope, and faith in treatment are important components of a client's response to psychological intervention.

A large number of individuals have benefited from the Medicare scheme since inception. Many most likely would not have sought treatment if it was not government funded. Medicare is the best system to provide individuals with provider options.

I sincerely hope that the government re-considers these cuts and changes, and perhaps reviews alternative methods of cost-saving.

For instance, General Practitioners are paid for each referral under the scheme. An option would be to ensure that the referral covers the annual period, and not a set number of sessions.

Also, rather than clinical psychologists having to refer their more complicated patients back to their GP to obtain a medical referral to a psychiatrist, it would make more sense for the psychologist to be able to refer directly.

Thank you for considering this feedback.

Yours faithfully

References

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