To: The Senate Community Affairs Reference Committee inquiry into Commonwealth Funding and Administration of Mental Health Services.

Please find below my opinion regarding Commonwealth Funding and Administration of Mental Health Services. I have submitted a number of comments, opinions, findings and recommendations under headings consistent with the terms of reference, however, due to the complexity of, and overlap between, a number of these areas, the entire document should be regarded as relevant in all areas of Mental Health Services.

b) Changes to the Better Access Initiative,

(ii) the rationalisation of allied health treatment sessions and

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

I am deeply troubled by the proposed cuts to the maximum number of Medicare rebated psychological consultations under Better Access funding per annum (from the current 6 plus 6 with a possible 6 more (up to 18 per annum) to 6 plus a possible 4 (up to 10 per annum) which are due to come into effect from 01 November 2011.

Any cut to the present maximum of 18 permissible annual Medicare subsidised consultations directly undermines the most unique contribution of the Clinical Psychologist and other mental health professionals to evidence-based and scientifically-informed mental health treatment. The most vulnerable population cohort will be those who cannot afford to fully pay for their remaining mental health treatment. It is extremely disappointing that the government is introducing inequality into the provision of specialised mental health care in Australia.

Reducing available Medicare funded consultations from a possible 18- to 10- per- annum will, at best, simply be redundant (because a particular client does not need them) or, at worst, compromise the entire course of treatment. Medicare Australia and the NHRMC recognises that the gold standard treatment for a number of mental health disorders, including anxiety and depression, is cognitive behaviour therapy (CBT). Worldwide research typically supports CBT intervention for between 12-20 sessions for most single-disorder presentations.

The government is risking the fidelity of CBT by reducing available sessions to ten. The likely outcome of this reduction is that a client will respond to treatment, only to have to cease

treatment before it is clinically advised. Clients may thus be exited from treatment before clinically sustainable gains are cemented, and before relapse prevention strategies are undertaken. Clients will remain at significant risk of relapse with fewer skills in managing their symptoms in the longer term, which will then be likely to translate to increased health costs and poorer clinical outcome in the longer term. I believe that the current budget proposal lacks insight into some of these processes.

Psychologists abide by a code of ethics that states that they are not to provide a service to an individual who does not need that service, thus extra sessions are not used unless it is clinically relevant. Evidence for this is that 21% of clients received 7-12 sessions, and only 5% received 13-18 sessions. CBT programs delivered by psychologists and other appropriately trained mental health professionals have an internationally accepted and proven evidence base for the treatment of depression, anxiety, trauma, dependency and a range of other psychological disorders. Limiting clients to ten sessions regardless of individual need is akin to limiting number of hospital visits or number of days in hospital, or number of visits one may make to a GP, or even, limiting active treatment for, say cancer; regardless of clinical need, or, similarly, telling patients that the most appropriate treatment is a course of antibiotics, but that they are only allowed to have half the course. The guide to whether a person needs a particular number of sessions, treatments or visits in other medical areas is not determined by budgetary constraints but by individual need. Clinical Psychology is no different! No other medical intervention is limited by budget constraints in this manner.

A second significant problem with the current budget measures is that the 5 percent of individuals who currently see a psychologist for between 13 and 18 sessions will no longer be able to receive continuity of service. Those clients who require more than 10 sessions will instead either have to wait until the next calendar year to resume therapy, at risk of any therapeutic gain being eroded, or must be shuffled into an alternative service, many of which have unacceptably long waiting lists, thus also risking erosion of therapy gain. The most distressed clients; those in need of further treatment will face discontinuity of service at a time when they are most in need.

A third issue is that those consumers with mild to moderate mental health presentation, which would ordinarily be treated to relapse prevention stage in less than 10 to 12 sessions, may have the important relapse prevention portion of treatment skimmed over, or not undertaken at all, thus, clients who would otherwise be expected to experience clinically significant improvement

may not achieve that, and be vulnerable to relapse, with no option but to wait until the following calendar year to access services; because if their presentation was mild to moderate they are extremely unlikely to be triaged into public mental health services. There is an overall risk of adverse social and wider economical impact from stopping treatment prematurely for these otherwise productive and well functioning members of society.

(e)

(i) and (ii) the two-tiered Medicare rebate system for psychologists and workforce qualifications and training for psychologists

In my opinion, the so-called two-tiered system of rebates for psychologists is a misnomer. Rather, Medicare rebates include different items of service delivery, including different rebates for different services. There are a number of salient precedents for having a two-tiered Medicare rebate system in particular professions. For example, General Practitioners attract different rebates for consultations than do specialists, and different medical specialties also have different rebates across services.

Clinical Psychologists are recognised as having specific expertise in mental health across Australia, the USA and UK, in the same way that, for example, Organisational and Forensic Psychologists have specific expertise in their particular area of training. Mental health is the specialty of Clinical Psychologists. There are a number of examples of employment opportunities in which psychologists who have further postgraduate training and supervision in a specific area are remunerated differently. For example, in the South Australian public sector Organisational Psychologists are classified differently from, and receive a higher rate of pay, than Clinical Psychologists. A number of Forensic Psychologist positions in the SA Dept of Corrections are also classified at a higher level than the usual level for psychologists. The profession of psychology, similar to Medicine, has long embraced diversity and specialty, and includes a number of specialised endorsements which are crucial in ensuring that psychologists can hone skills in particular areas, and thus benefit their clients. For example, the Australian Institute of Sport does not seek to employ Forensic Psychologists, and a Developmental and Child Psychologist is more likely to be working in a school or educational or private setting, rather than in an adult prison.

Clinical psychologists have (at least) an additional two years of postgraduate coursework, research and supervision following a four year undergraduate degree. The supervision that is undertaken is across a number of areas, as prescribed by the Australian Psychology Accreditation Council (APAC) On top of that, Clinical Psychologists also have additional specialised supervision following successful completion of either a Masters of Clinical Psychology, a Ph D in Clinical Psychology or Doctorate of Psychology, and, further, on top of that, they continue to hone their Clinical Expertise by undertaking specific professional development activities every year.

So-called Tier 1 psychologists may have completed a three year undergraduate degree following by a single honours year or diploma, and have undertaken two years of supervised practice with another psychologist, many of whom have also been trained in this same method. They may also have completed a Masters level postgraduate degree in another area (Non-clinical), or have chosen, following a Masters of Clinical Psychology, to not pursue further supervision under the auspices of an experienced Clinical Psychologist. These psychologists do not have the level of training in mental health that Clinical Psychologists do.

Apart from Psychiatry, no other discipline receives as advanced training across the lifespan and the entire spectrum of complexity, severity and range of mental health disorders as the Clinical Psychologist. Clinical Psychology is the only allied health discipline whose entire postgraduate training is in the field of advanced evidence-based and scientifically-informed mental health assessment, diagnosis, case formulation, consultation, treatment, evaluation and research. Clinical Psychologists are frequently referred the most complex and severe mental health presentations. As such, their expertise will be wasted, if the current proposed budget measures are allowed.

Given the significant differences in the training and expertise between “generalist” psychologists and Clinical Psychologists outlined above it is expected that there would be a difference in service delivery and outcome. I note that other submissions to this enquiry have elaborated service delivery discrepancies between clinical and generalist psychologists, and thus I will not elaborate on that here.

Of particular note is that whilst on face value it appears that the evidence from preliminary evaluation of the Better Access program suggests there is no difference in outcomes for consumers who accessed psychologists or clinical psychologists or GPs, and whilst findings

from Component A of the Better Access evaluation were overwhelmingly positive, overall there are a number of concerning methodological problems with that research. In particular, there was no clear assessment or diagnosis, or recognition of co-morbid or secondary diagnoses, and the outcome measure, the K10 does not adequately determine clinical improvement. This measure is not psychometrically robust across disorders. It was impossible to determine from the findings what differences there may have been between groups referred to different types of practitioners. Therefore, no conclusion across service delivery type may be drawn from the data presented. In my practice, I am aware that a number of GPs refer clients with more difficult co-morbid conditions to clinicians with clinical college endorsement, while more 'routine' presentations are referred to generalist practitioners.

A very important consideration to the Senate is that a number of Clinical Psychologists working in private practice specialise in specific areas of mental illness. A number of these are psychologists who have studied clinical psychology at a Doctorate level. These Doctors of Psychology (Psy D), or Ph D trained Clinical Psychologists often practice mainly in the area of their Doctoral level studies: For example, in the highly specialised areas of Eating Disorders, Autism Spectrum Disorders, Post Traumatic Stress Disorder, Obsessive Compulsive Disorder, Psychosis and Sleep Disorders, to name a few. These Clinical Psychologists are experts in their field, and often have internationally recognised status as experts, and have presented at international conferences and published findings in peer reviewed international psychology and psychiatry journals of the highest calibre. Clients and Families of clients who suffer the above-mentioned disorders are extremely relieved to find that they can access privately practicing Clinical Psychologists who have specific expertise in treating these disorders, and are prepared to travel out of their GP network area to access these specialist clinicians. Under the current budget measures, these consumers will be more likely to be referred to allied health professionals that are employed under ATAPS provisions, and whilst they may have available up to 18 sessions per year through ATAPS funding, unfortunately the very professionals with expertise in these specific disorders will likely be inaccessible through ATAPS. Anecdotal evidence among the professions is that a number of clients have already been misadvised that they are unable to access the mental health clinician of their choice and that they must attend local services, providing further evidence that consumers of mental health services may not be referred to the most appropriate service through regional schemes.

If the current, well justified, so called two tiered Medicare rebate system were dismantled, and recognition of the extensive further postgraduate and beyond training that Clinical Psychologists experience was removed, likely outcomes would be that consumers would be disadvantaged. The current recommended fee for a typical length psychological therapy session, set by the Australian Psychological Society, is $216.00. Very few psychologists charge at that rate, and a vast number of Clinical Psychologists bulk bill clients who are experiencing financial difficulty. As it is, there is no provision in the Medicare Australia items to bill for telephone calls between referring specialists and GPs and Psychologists, or for correspondence, thus, this work is not recognised or rewarded, reducing psychologist's capacity to earn a reasonable living consistent with having six to eight years of tertiary study and further ongoing supervision as required by the APS colleges and AHPRA. Any reduction in rebate would put further pressure on their capacity to deliver therapy to marginalised clients that are currently bulk billed, and undermine their capacity to undertake extra tasks that are currently unpaid. A byproduct of this is that if specialist psychology service such as that provided by Clinical Psychologists was not remunerated consistent with the extra burden of study, help fees, ongoing commitment to professional development and adherence to best practice from a scientist practitioner perspective, the outcome may be that University courses in Masters or Ph D level training of Clinical Psychologists would be devalued and potentially not attract the calibre of students currently enrolled. This outcome would have dire consequences for the profession of psychology as a whole and provision of service into the future. If, as some would argue, there is no difference between a generalist and clinical psychologist, then it follows that there is no need for postgraduate training in psychology. This notion is clearly flawed, in the same way that if psychiatrists had the same rebates as GPs there would be far less incentive to specialise!

Notwithstanding the fact that Clinical Psychologists (and any other psychologist who is a member of any college, or eligible for membership) have specific expertise in a specific area of psychology, namely Clinical (or mental health) Psychology, it should be noted that all registered psychologists have expertise in the delivery of psychological intervention. Psychologists who are not specialised Clinical Psychologists likely have a good argument for an increased rebate over other allied mental health professionals such as occupational therapists and social workers. By its very nature, their undergraduate training in psychology is more "psychological" than that delivered to OTs or social workers.

I am aware that in November 2010, the Government announced that it was planning to cease Medicare rebates to OTs and social workers, and that they then backed down on that due to pressure from Divisions of GPs and the AASW etc. It is curious that less than 12 months later, the budget announcement was to reduce sessions for clients across the board instead. As noted above, Clinical Psychologists have the highest level of training in clinical (mental) health after psychiatrists, and Medicare rebates should reflect that. Generalist psychologists have a higher level of training in psychological principles and intervention than other allied mental health professionals, and thus, Medicare rebates should also reflect that.

C) the impact and adequacy of services provided to people with mental illness through the ATAPS program:

Budget measures that redirect money from Better Access to ATAPS are likely to result in patients with the highest levels of illness, the moderate to severely mentally ill, being referred to those allied health clinicians with less training in clinical mental health (see above for a description of training differences between specialised areas of practice endorsement).

Divisions of General Practice are reportedly employing generalist psychologists at uncompetitive salaries which do not attract specialist Clinical Psychologists. Clinical Psychologists are more likely to be working in specialist facilities or in private practice. They are less likely to be employed by GP networks, and thus, are less likely to be working for ATAPS funded facilities, or other centralised services. ATAPS services are likely to attract generalist psychologists and other allied health professionals who do not have the level of expertise that Clinical Psychologists have, thus, the very service that is supposed to target Tier 3 funding for severe and persistent mental illness will lack the most highly trained clinicians with specific expertise in treating severe mental illness.

The budget commentary indicated that "independent evaluation of Better Access found that it is not always able to help people in hard to reach populations". In that case, diverting funds from Better Access would not improve this situation. Rather, referring agencies need education to improve referral pathways to Better Access.

Diverting budgetary funds from services that have been shown to be effective, to dole out to alternative services, with funds being released over a number of years will disadvantage those clients who may need more than 10 sessions in any one year. In the interim, there is a serious

question as to how the gap in service provision will be filled. As I understand it, Medicare Locals are designed to take over from GP Networks, and are to contract local Primary Care agencies to provide programme specific services such as ATAPS. This will serve to centralise services and stigmatise clients who currently access psychological therapy from professional rooms. Tendering for psychological services will put downward pressure on services and attract less experienced clinicians, thus is economically short-sighted. There is no evidence that limiting CBT for moderate to severe mental illness is effective. On the contrary, many more severe illnesses require more than 12 sessions.

The Budget information stated that Better Access was to be for mild to moderate mental illness, however, findings to date demonstrate that Better Access is currently treating moderate to severe mental illness, with proven results. Given the level of expertise of clinicians providing services under Better Access, it is right that Better Access also address moderate to severe mental illness. A number of clients are referred for depression or anxiety, and on evaluation by the treating Psychologist it becomes apparent that the underlying condition is long standing and debilitating with co-morbidities which are not immediately apparent to the referring GP, but that emerge during therapy, following establishment of rapport. For example, numbers of clients present with depression or anxiety, and when they attend the psychologist appointment, disclose significant alcohol and other drug dependencies. In addition, clients with prior history of eating disorder may have a relapse of symptoms when their presenting disorder is treated, just as clients with OCD may present initially as having social phobia or health anxiety. GPs cannot predict these eventualities, but their existence points to the necessity for Better Access to include a set of appointments for this type of eventuality so that clients are not routinely onward referred whenever they present with more severe illness. It is known that a therapeutic alliance is a good predictor of outcome, thus, clients who do have co-morbid and severe mental illness benefit from longer term engagement with a therapist they trust and will attend, and having to onward refer clients whose condition was more serious than the referring GP initially thought is detrimental to their mental health. Clients find it stressful to move to new services and alternative clinicians, and eroding the Better Access limit of available sessions will increase the likelihood of this occurring, compromise client's access to services due to many clients not wanting to reengage with an alternative service. Additionally, it is a waste of economic resources to refer onward and have one or more sessions spent dealing with handover, when one or two more sessions with the original therapist may have been all that was required to secure relapse prevention strategies. Similarly, it is false economy to have the

most experienced and rigorously trained mental health clinicians, the Clinical Psychologists, in a position of having to refer back to GPs for onward referral to ATAPS clinicians who, as outlined above, are unlikely to have the level of training and expertise that the endorsed specialist Clinical Psychologist who was currently seeing the client has!

Much of the announced ATAPS funding is for the Tier 3 funding ("severe and persistent" mental illness). Divisions of General Practice have stated that, once programme-related overhead and administrative costs are deducted, there is provision for an approximately 0.8 EFT salaried clinical position dedicated to the Tier 3 program. Divisions of General Practice will be superseded by Medicare Locals, which are likely to be made up of approximately 3 current Divisions. One clinician working less than full time will thus be expected to service the equivalent of three current Divisions of General Practice. This is clearly not enough, particularly in the context of potentially reduced Better Access sessions.

Better Access has been shown to provide a service for moderate to severe symptom presentation, and to be successful and cost effective. If Better Access is dismantled by erosion of number of available services, clients who are currently accessing services in these areas will be shunted onto waiting lists to see less experienced clinicians.

We are all acutely aware of the prevalence of psychological disorders in the Australian population. For example, the 2007 National Survey of Mental Health and Wellbeing conducted by the Australian Bureau of Statistics found that an estimated 3.2 million Australians (20% of the population aged between 16 and 85) had a mental disorder in the twelve months prior to the survey. Similarly, an Australian primary care study found that 36 per cent of those attending primary care settings have symptoms of psychological disorder and 20.5 per cent report both anxiety and depressive disorders (Harris et al., 1996). A significant proportion of these members of society may benefit from treatment, thereby improving quality of life, productivity, and general wellbeing of individuals and families. The support provided by the Better Access scheme could be central in addressing the mental health needs of Australians in the future.

The Australian Psychological Society surveyed consumers who received psychological care through Better Access. This study sought the views of 2,223 consumers. Ninety percent of them reported that the treatment they had received led to "significant" (45%) or "very significant" (45%) improvement." Psychologists cannot be expected to sustain these excellent

outcomes if their ability to provide services has been cut from 18 to 10 sessions. The most rigorously trained clinicians after psychiatrists cannot be expected to yield this level of results if they are only referred those with ‘mild to moderate’ mental illness, and those with moderate to severe mental illness are instead referred to services that have limited capacity to engage them and less rigorous training. Consumers require access to evidence based treatment for the duration that scientific findings have found again and again to be necessary for sustained improvement and reduced relapse.

Rather than limit number of sessions to 10, Better Access would be enhanced by increasing the available annual sessions to increase consumer’s likelihood of effective clinical improvement and prevent relapse. Now is not the time to reduce services for people with significant mental health problems or to divert funds from existing services that have been shown to be efficacious compared to alternative models that have high overheads and are considerably less efficient economically. I would recommend that not only should the current session count be preserved, but that there be provision for an additional "one-off" of up to 8 extra sessions in the first calendar year of treatment, for any consumer who presents with co-morbid conditions or those that research findings show that 20 sessions are required to prevent relapse. In subsequent years, the session limit could be preserved at 12, for those clients who may need ongoing intervention, such as those with personality disorders, psychosis, OCD, or eating disorders or a course of treatment for a separate disorder.

In summary, Clinical Psychologists are more rigorously trained in mental health than any other mental health professional apart from psychiatrists, with between 6 and 8 years of full time equivalent tertiary study (four undergraduate and up to four postgrad) with an additional one or two years of practice supervised by another Clinical Psychologist along with ongoing specific clinical professional development yearly, compared to either 4 years of undergraduate study followed by two years supervised practice or six years university study in a psychology specialty other than clinical (i.e., not mental health specific), or other allied health professionals where three or four years of undergraduate study lead to a professional qualification. Medicare rebates for Clinical Psychologists should reflect their high level of training and service delivery. Generalist psychologists’ expertise in psychology should also be reflected in rebates commensurate with their training, compared to those afforded other allied health professionals with less rigorous and specific training in psychological theory and practice. Further, the Better Access programme quality would be considerably undermined and

delivery compromised if sessions were reduced from potentially 18 to 10 per annum, both because the Gold Standard treatment of choice for a number of mental health concerns is CBT, and because CBT protocols recommend up to 20 sessions for adequate treatment including relapse prevention strategies. It is important to acknowledge that psychologists adhere to an ethical stance that therapy will not be encouraged in situations where it is not necessary or helpful, such that any reduction of sessions from 18 to 10 would serve only to disadvantage those clients who are actually in need of further therapy. In addition, reducing sessions will serve to put further pressure on systems such as ATAPS, which, as outlined above, are more likely to attract less qualified clinicians, are likely to have budget constraints and service delivery overheads that undermine the service delivery. Consumers' outcomes will be jeopardised by a reduction of sessions under Better Access, due to a lack of continuity of treatment, missing or inadequate relapse prevention and limited onward referral pathways. Finally, failing to recognise the differential expertise of clinical psychologists in mental health may serve to undermine the value of clinical psychology as an area of specialty which would have enormous adverse implications for the profession, for clients in need of specialised treatment, as well as implications for enrolment in clinical Masters courses at University level.

Yours Sincerely