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To the Senate Community Affairs References Committee

RE Commonwealth Funding and Administration of Mental Health Services

My submission is based on my experience as a Specialist Clinical Psychologist. I give some personal information as specialist training in psychology is often poorly understood outside the narrow orbit of psychiatry and particularly when outside of Western Australia. I was trained and registered under the Western Australian Psychology Board (WAPB) system that required both postgraduate qualifications in my area of specialty (Clinical Psychology) followed by a period of two years of Board-approved supervised practice as a Registrar. My Registrar period was spent at Royal Perth Hospital within adult psychiatry. In that Registrar role and in the subsequent six years of full time specialist practice within adult mental health settings I was routinely required to assist Consultant Psychiatrists to determine diagnosis of difficult cases, particularly on first presentations where collateral information was limited. Other routine duties included full clinical interview and psychometric testing for the purpose of assessment, diagnosis, treatment planning and treatment with evidence-based psychotherapy for individuals, families, and groups. The planned psychological intervention also often included and always considered the wider systems within which the individual, family or couple lived and interacted such as the psychiatric ward and other hospital wards and ward staff when indicated. I have supervised Psychiatry Registrars in their psychotherapy of patients and supervised clinical psychology post-graduate trainees and Registrars. I have also played a major role in establishing the first Psycho-Oncology service within WA Department of Health (DoH). I would like to further mention and emphasise that as a Specialist Clinical Psychologist within WA DoH, the course, nature, length of psychotherapy or psychological intervention given my patients was always and absolutely a matter of my own discretion and based on my own professional judgment stemming from my understanding of the clinical need of the patient. This clinical judgment and understanding was put to peer scrutiny, initially as a Registrar with my individual supervisor and later as a Registered Specialist to my peers in peers supervision. Medical doctors including Consultant Psychiatrists had no supervisory role over my work. Rather we had a mutual consultative relationship where opinion was sought of the other. My training does not simply give me an in depth understanding of psychological assessment and intervention but additionally gives me this valuable model of practice in which my work is open to peer review. I of course carry this model of practice with me into my private work and regularly consult peers more highly trained specialists on my work.

I now work primarily in private practice and find that in this setting my specialist training is of even greater importance. Another important aspect of my model of practice gained through my specialist training is the understanding of when, how and

why to refer a patient for psychiatric assessment, or facilitate admission to a psychiatric hospital. I am (as is any Specialist Clinical Psychologist) indeed better trained in mental health concerns, treatment and assessment than most GPs. Further, no other allied mental health professional receives as high a degree of education and training in mental health as the clinical psychologist (1) . **Postgraduate trained Clinical Psychologists have specialist training in the diagnosis and treatment of mental health disorders and a robust model of practice that ensures we keep our focus on clinical need of the patient and up to date in our reading. Our skills could be better used than the current Medicare or MBS arrangement allows and I will make recommendations on this.**

The present issue of the funding and administration of mental health services also calls us to consider most the desired future direction of mental health services in Australia. I would like to make some general observations regarding the state of psychology as a profession in Australia. Clinical Psychology is an internationally recognised specialty within the broader discipline of psychology. When the WAPB was disbanded in order to bring all Australian psychologists under a single national board (PsyBA), Australia lost the only jurisdiction in which clinical psychology training met an international standard. Those who met the criteria for Specialist Registration by the WAPB are in line with international standards, although many countries such as the USA and NZ now require Clinical Psychologists to do a minimum of a doctorate degree (rather than Masters) followed by internship. Regrettably even under the WAPB it was possible to become fully registered as a psychologist and hence permitted to do any kind of independent clinical work with as little as an undergraduate degree and a period of approved supervision. In no other OECD country could a person with such little training be permitted to practice independent of supervision, irrespective of years of experience in the job (Pachana & Helmes 2006). No equivalent country to Australia will permit full registration as a psychologist without applied post-graduate training. In the UK, for example, a person with undergraduate qualification can only ever work as an assistant to and under the direct supervision of a post-graduate trained psychologist. Supervised practice is not and cannot be equivalent to a transparent, competitive, dedicated, intensive and rigorous university training. Such training is the only safe, equitable and transparent start to a professional life in which the individual clinician will often hold the safety of the patient, sometimes in life and death but always in terms of possible re-traumatisation if diagnosis is missed and the subsequent treatment inappropriate. It is not possible to know what one does not know. Misdiagnosis can lead to prolonged ineffective treatment. It has been my experience that the less qualified often do not recognise the problem or are aware of only one factor when multiple factors are in play and therefore deliver the wrong or ineffective treatment. The patient then must continue to seek out someone with specialist skills or worse give up with the belief they cannot be helped. I am a passionate advocate for the recognition of advanced training in psychology because I am a passionate advocate for the safety and dignity of my patients who deserve and need the best possible care. Without advanced training such as can only be delivered through a rigorous university course that comprises diverse clinical placements, and clinical registration period, there is no transparency and no equity. It is not uncommon for patients with complex problems to take many years (often decades) to find the treatment they need. This is in part because our Australian system now presided over by the PsyBA, does not make it easy for patients to understand who is treating them.

Specialist Clinical Psychology skills have been described thus,

“Level 3 - Activities which require specialist psychological intervention, in circumstances where there are deep-rooted underlying influences, or which call for the discretionary capacity to draw on a multiple theoretical base, to devise an individually tailored strategy for a complex presenting problem. Flexibility to adapt and combine approaches is the key to competence at this level, which comes from a broad, thorough and sophisticated understanding of the various psychological theories

And contrasted to lesser psychology skills expected of any mental health care professional (also retained by the specialist),

“Level 1- "Basic" Psychology - activities such as establishing, maintaining and supporting relationships; use of simple techniques (relaxation, counselling, stress management)

Level 2 - undertaking circumscribed psychological activities (e.g. behavioural modification). These activities may be described by protocol”

(Management Advisory Service (1989, p.6)

I will now move on to address certain of the Committees terms of reference.

(a) the Government’s 2011-12 Budget changes relating to mental health

The changes muted in the 2011-12 budget are very disturbing in relation to finding the best fit of services for patient need. The Better Access initiative was a great step forward for mental health in this country. For the first time ever, some small provision was made under the MBS that enabled access for those with mental health problems, to suitably qualified mental health professionals besides psychiatrists. Prior to Better Access the only other avenue was through private health rebates or to join the long waiting lists for treatment in state mental health services. These state services necessarily put emphasis and priority in treating the most disabled by their mental illness. Typically those treated in our state mental health care sector are so severely disabled by their mental illness to be either invalid pensioners or to have a work history of long periods of unemployment and poorly paid work. Better Access the first Medicare i.e., universal benefit given to the Australian community. The 6+6+6 service allocation for psychology consultation was minimal but important and useful to those suffering less complex mental health problems. The loss of any of these already minimal benefits threatens the viability of the program at all. The proposed 6+4 (10 psychotherapy treatments) is simply too ‘low a dose’ to be therapeutic, except as a preventative measure for those with mild symptoms that as yet do not meet full criteria of a mental illness. I will mention the ill advised plan to send the most complex, chronic mental health presentations to ATAPS programmes in (bii) below.

Recommendations

- Retain the up to 18 possible consultations to all Medicare registered allied health practitioners and retain the 6+ medical review system for general allied health.
- In the case of Specialist Clinical Psychology, increase the up to 18 possible consultations to a minimum of 20.
- In the case of Specialist Clinical Psychology a further allocation of an additional 20 consultations within a calendar year based on clinical need as determined by the treating Clinical Psychologist or referring Psychiatrist (for chronic and complex mental health

conditions such as personality disorder, recurrent chronic depression, chronic post-traumatic conditions, reactions to severe prolonged stress and adjustment disorders associated for example with serious chronic health conditions like cancer and chronic pain).

(b) changes to the Better Access Initiative, including:

(i) the rationalisation of general practitioner (GP) mental health services

It is important that as many people as possible have access to some kind of mental health service. GPs are well placed to provide supportive counselling and should be encouraged to do so. GP mental health plans should be retained when accessing allied health professionals with less extensive mental health training such as psychologists without post-graduate training, social workers and occupational therapists. Most GPs do lack advanced training in mental health (this is understandable and ought to be taken as given) and there could be better use of the skills and training of Clinical Psychologists. It makes little sense for a GP whose training is less extensive in mental health care to make an assessment when referring to a Clinical psychologist. Proper recognition of Clinical Psychologist expertise would negate the need of GP assessment and GP mental health plans when referral is made to a Specialist Clinical Psychologist. Additionally, many people with mental health problems do not want to discuss these in any detail with their GP and would prefer to be able to refer themselves directly to a clinical psychologist. Private health funds such as HBF in WA have for many years allowed patients to access a clinical psychologist without need of a GP referral. Medical review of a patient attending a Clinical Psychologist ought to be at the discretion of the Clinical Psychologist and the patient and not mandated by MBS in a 'one size fits all' paradigm that bears no relation to therapeutic outcome or need. Many of these medical reviews are unnecessary and worse they can be destabilising to the psychotherapy when a less skilled practitioner does such an assessment. The treating Clinical Psychologist would be required to write back to the GP advising of diagnosis and treatment plan, as per any other specialist referral. GP services could be rationalised in this way without disadvantaging the patients who prefer to include their GP in their treatment.

Recommendations

- GP rebates for mental health plans retained as per 2010 with the following changes
- Where referral is made to a Clinical Psychologist, the GP need not complete a Mental Health Care Plan but simply send a referral note as per referral to a Psychiatrist and receive the equivalent rebate as when referring to psychiatry.
- Specialist Clinical Psychologists be granted MBS items to allow for direct assessment by the Clinical Psychologist without the need of GP or Psychiatrist referral or assessment.
- Where a GP or Psychiatrist makes referral to a Clinical Psychologist, medical review is at the request of the treating Clinical Psychologist or patient (and not mandated by MBS after every 6 hours).

(ii) the rationalisation of allied health treatment sessions

The 6+6(+6) service allocation for psychology consultation was minimal but important and useful to those suffering less complex mental health problems. The loss of any of these already minimal benefits threatens the viability of the program at all. The proposed 6+4 psychotherapy treatments is simply too 'low a dose' to be therapeutic, except as a preventative measure for those with mild symptoms that as yet do not meet full criteria of a mental illness (Harnett et al, 2010). In my practice about one third of patients require 18 treatments and of those more than half require in excess of 18. These people have very complex presentations that are both chronic and severe. These

patients typically have had a chronic course of problems beginning with early developmental abuse, neglect, and trauma. Some additionally have a chronic illness such as IBS, MS or cancer and some have multiple illnesses additional to mental illness. Typical adult experiences within this group include repeat trauma, family break down, domestic violence, multiple psychiatric hospitalisations, suicidal impulses or attempted suicide. They typically have tried many places to get appropriate care and most have stories of under trained professionals who were not able to help them. This group is particularly vulnerable and most in need of Specialist Clinical Psychology services. It is of great concern that the Federal Government proposes that such patients should be treated through the ATAPS programme when very few specialist trained psychologists work in that programme. This is the very group least suited to focused psychological strategies and most in need of specialist, individually tailored psychotherapy that Clinical Psychology training enables us to do. This is the very group that most needs the advanced skills of a Specialist Clinical Psychologist. I have had to drastically reduce my fee to an unsustainable level for some in this group for whom termination of therapy would recapitulate earlier trauma and loss. This group that most needs my services will be most unfairly and disproportionately affected if this reduction in services goes ahead. We need to increase services to this population and not decrease them.

Recommendations

- The proposed reduction is not based on any clinical evidence and is inadequate to treat mental illness. Retain the up to 18 for all presentations. This does not prevent quick interventions for the more mild conditions where less than the maximum consultations will continue to be used and it allows for more diverse need, which is reflective of the real clinical situation.
- Increase the up to 18 possible consultations to up to 20 where referral is to a specialist, postgraduate trained Clinical Psychologist.
- In the case where a specialist, postgraduate trained Clinical Psychologist is providing the service, there be further allocation of an additional 20 consultations within a calendar year based on clinical need as determined by the treating Clinical Psychologist or referring Psychiatrist (for chronic and complex mental health conditions such as personality disorder, chronic recurrent depression, chronic post traumatic conditions, complex grief).

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

(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

This proposed reduction will have a most deleterious effect on patients being treated for mental illness of complex aetiology and for whom problems have already run a chronic course, irrespective of whether this are now of mild or moderate or severe, severity (NB complexity of problems does not necessarily imply severity of symptoms nor vice versa). For this group (chronic, complex as in the case of personality disorder) I make the recommendation for additional, not less rebated consultations as in bii above. These patients often have no other recourse to specialist services and may be left on a revolving door of hospital admissions with inadequate follow-up.

For all other mental health patients I recommend a continuation of the minimal starting point to Better Access, the 6+6+6.

(c) the impact and adequacy of services provided to people with mental illness through

the Access to Allied Psychological Services program

(d) services available for people with severe mental illness and the coordination of those services;

(e) mental health workforce issues, including:

(i) the two-tiered Medicare rebate system for psychologists,

It is essential that the higher level of skill attained through specialist training be recognised in fee structure and that the two tier structure remain. Australia is already a shameful last, a world trailer, when it comes to professional standards in the profession of psychology. Patients must be given higher rebates to cover the higher fee that Specialists ought to be able to charge for their services and that recompense for long and difficult training. There is an industrial issue here and a precedent in WA industrial relations case (1).

Recommendation

- Retain two tier payment in psychology

(ii) workforce qualifications and training of psychologists, and

I have outlined a general position within my introduction: It is important that Australia takes up the challenge to lift standards of training in psychology to our international peers. Progress in this matter is partly due to division within the profession. There has been a profound lack of leadership from the profession's historical representative body, the Australian Psychology Society (APS). Despite repeated efforts of the Clinical College of the APS over many decades, no progress has been made. This organization has not progressed standards within the profession for many decades. It has instead engaged in a shameful and cynical bid to keep poor training standards and appease the bulk of its membership. Many pre-eminent and highly respected members of the profession recently left the APS in protest at that organizations' intransigence on maintaining even its own standards and I also resigned. The Australian Clinical Psychologist Association of which I am a founding member has formed to offer this needed leadership. It is necessary that patients and referrers can transparently choose the clinician by their qualifications and these should be set to the standards of comparable countries.

Recommendations

- Australia move more assertively toward meeting international training standards for psychology.
- That the proposed new 5+2 pathway not be adopted. It is not established and does not go far enough to meet international standards. Instead the minimum qualification move immediately to the already well established and approved clinical (and other specialist) masters programmes.
- That the 4+2 pathway be ceased immediately as a way to full registration with only those currently pursuing it being grand-parented as registered psychologists. This category would cease to exist as those who hold it leave the profession under natural work force attrition processes.
- That those who have completed the specialist requirements as per the WAPB system be granted Specialist registration.
- That those endorsed by the PsyBA who lack post graduate qualifications from approved courses in the speciality area for which they are endorsed not be given specialist registration but remain as 'endorsed'.
- The PsyBA move immediately to adopt an approved programme of supervision for the purpose of specialist training, based on the template provided by the WAPB, which was in turn based on international requirements.

(iii) workforce shortages;

There are no real work force shortages in the area of psychology except for specialist psychologists. With the exception of WA there has been little incentive for psychologists to attain higher degrees. This could be remedied by adopting appropriate international training standards. All the necessary approved university postgraduate training programmes exist but more incentive needs to be in the system to encourage the pursuit of excellence.

Recommendation

- Australia move more assertively toward meeting international training standards in psychology

(f) the adequacy of mental health funding and services for disadvantaged groups, including:

(i) culturally and linguistically diverse communities,

(ii) Indigenous communities, and

(iii) people with disabilities;

(g) the delivery of a national mental health commission; and

Recommendation

- It is imperative that the term “allied health” stop being used as though it referred to a profession and as though all other professions are only allied to health. We are as much a part of health as doctors and nurses. It is not sufficient to have “allied health” represented unless this means representation from each of the diverse professions in this catchall is included. Clinical psychology is an essential profession to be represented within any mental health commission.

(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; and

Medicare

Recommendation

- An item is made available under MBS to allow clinical psychology consultation via telephone for use by people who live in rural and remote areas.
- (j) any other related matter.

References

(1) Work Value Document, (1998) Western Australia Clinical Psychology Health Sector

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