

**Commonwealth Funding and Administration of Mental Health Services  
Senate Inquiry: Community Affairs References Committee**

I thank the Senate and Community Affairs References Committee for the opportunity to comment upon the Terms of Reference for this very important inquiry. The Committee's openness to professional opinion in the area of Mental Health is greatly appreciated.

I have only included the Terms of Reference on which I have felt confident to comment.

**Explanatory Note**

The language used and style of expression in this letter is as objective as I can possibly be. As I am unaware of the experience of the Committee with psychological disorders, I do not know how much of what I write will be familiar to them and I respect whatever experience the Committee may have or not have in this area. My comments are as factual as possible in the context of my clinical experience and there is no exaggeration in any way.

Throughout this document I refer to "Clinical Psychologist" or "Clinical Psychology" as this is my speciality. While I am aware Medicare funds Psychologists who have a general level of training, my opinion is that people with mental illness require a specialised level of assessment and treatment.

**Professional Background**

In order to understand the context of my opinions below, it may be useful to know something of my professional background. I obtained full registration as a Clinical Psychologist in Western Australia in July 1987. I have worked continuously since this time in the public welfare system, public health system (inpatient & outpatient), public mental health system (inpatient and outpatient), university counselling services as well as in my own private clinical psychology practice since July 1995. My work locations include remote rural Australia as well as metropolitan cities.

My professional experience began in the area of working with emotionally and behaviourally disturbed children and their families as well as adults with a range of mental health problems. Since October 1994, I have worked solely with adults, many of whom have had chronic & severe emotional and psychological problems for many years.

I have also worked with adults with less chronic and less severe issues whose psychological treatment. However, for the purpose of this document, I am drawing most of my comments from the experience of working with the most severely and chronically affected people whom I have treated.

**Response to the Terms of Reference**

**(a) the Government's 2011-12 Budget changes relating to mental health;** Since the introduction of the Medicare rebate for the profession of psychology in November 2006, I have had a steady increase in the number of people seeking treatment for the psychological suffering. Many of my patients were previously unable to afford to pay for private treatment prior to the Medicare rebate. As most of them were also not eligible for public community mental health services (that is, they were not actively psychotic) or public hospital mental health services, they remained untreated until such time as they could obtain a rebate for their treatment.

Many of my patients are bulk-billed and I am aware of many skilled and highly experienced Clinical Psychologists who also treat low income individuals without a fee on top of the bulk-bill rate. This is a very fair and equitable manner in which to provide psychological treatment in the community. Patients are usually seen within a timely manner once a referral is received from the patient's GP. I understand that the current proposal is to reduce the number of Clinical Psychologist appointments under Medicare from 18 (12 + 6 'exceptional circumstances') to a maximum of 10 annually.

When I use the expression "to treat a patient" I mean that they continue treatment until such time as they can function well without a recurrence of symptoms, or if symptoms do recur the intensity is much less than the patient has previously experienced and they recover much faster because of the coping strategies learnt in therapy.

I have no doubt that should a reduction in the number of Medicare funded appointments with a Clinical Psychologist proceed through Parliament, an extremely precarious situation will emerge:

- (i) who I can agree to assess, and
- (ii) who I can actually treat.

Many patients have longstanding problems and it is potentially unethical to consider them for a thorough assessment followed by treatment when this would all need to be achieved in 10 sessions annually. An appointment, on average, once every 5.2 weeks is inadequate. Considering that a thorough assessment can take a minimum of 4-5 appointments then potentially within two-three months a patient would be without a treatment option.

When patients have the origins of their disorders in childhood trauma (as many people with longstanding depression and/or anxiety do) the treatment could not be adequately provided in the 5 appointments left over after assessment. It has been well known in the psychological research literature that most people who attend for psychological treatment of anxiety alone have had the disorder for at least 15 years<sup>1</sup>. As such, the Clinical Psychologist has to be aware of clinical priorities and be able to discuss these openly with the patient in order that treatment can be understood and agreed upon by all concerned.

My point here is that if I am unable to treat a patient in time afforded and there are few or no other free or low-cost options available, I will be left with no option but to refer the patient back to his/her GP for ongoing care. There is no such restriction on Psychiatrists who treat patients in private practice. *Clinical Psychology* is the only other profession whose training is on empirical methods of assessment and treatment of patients with mental illness.

Given the nature of this specialised area, if a patient no longer qualified for Medicare rebates and/or was unable to pay for their own treatment, I would need to refer the patient back to the General Practitioners who would then need to refer the patient onto yet another mental health provider - if the patient qualified for funding elsewhere. While I am aware of the ATAPS scheme, many of the providers of psychology services do not have specialist training as Clinical Psychologists do. I will comment later in this document about specialist training as patients with severe and chronic mental health problems need to be directed to Clinical Psychologists with specific training & experience in this area.

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

(i) I am unable to comment on this point.

**(ii) the rationalisation of allied health treatment sessions,**

Many of the comments I made in (a) above also apply here. I understand the term 'rationalisation' to mean "*reduction in number of appointments funded by Medicare*" and as such I have already specified my concerns about the provision of assessment, diagnosis and treatment to patients with severe psychological problems in 10 sessions annually.

I am also concerned about the inadequacy of terminology when describing a patient's condition as 'mild', 'moderate' or 'severe'. I do not know of a standard definition which has been agreed upon for the use of this terminology in mental health settings. A thorough assessment is required to have a clearer perspective on the severity of a patient's condition and also whether it is acute or chronic.

Most patients do not wish to have more appointments than they need. However, I have often found that patients require more appointments than the current system allows. Thus, to reduce the number of appointments available, especially to low SES and impoverished individuals, is in my view an abandonment of our citizens who are most in need of subsidised mental health care.

In my experience, many General Practitioners, make many appropriate referrals of patients with complex disorders. However, sometimes the GP is unaware of the nature of the complexity or the type of treatment that is actually required. It is very common for the referral letter which accompanies the Mental Health Plan to say something such as "*I am referring Ms/Mr X to you for cognitive-behavioural therapy for her/his anxiety and depression*".

My point is that the referral should ideally be made for the Clinical Psychologist to initially make a thorough assessment & to determine from this the most appropriate empirical method of treatment.

As a result of my assessments I often find that there are more pressing problems as well as co-morbid diagnoses that the GP is not aware of. While I would not expect a GP to be familiar with the nature of a full psychological assessment, my second point is that unless patients are assessed by clinicians with an adequate level of training in complex pathologies, many problems which can be treated may well go unrecognised by less qualified and experienced 4 year trained psychologists. Thus, it is not always possible for a General Practitioner to determine whether a patient's presentation is of a mild, moderate or severe level. Much of this difficulty pertains to not only the observable presentation of the patient in the doctor's office but also of the information the patient is willing to provide. Many patients are very guarded about how much they are willing to disclose until they have determined their level of trust for the treating practitioner - GP or Clinical Psychologist. Thus, it can be very hard for a GP to know both the severity and chronicity of a patient's problem. 'Screening questionnaires' are only that - screening to see who may require assistance - they are not diagnostic tools which is also something that is sometimes misconstrued within the referral letter and Mental Health Plan.

**(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**  
I am unable to comment on rebates for GPs.

However, I find that the requirement that a patient is return to his/her GP after six appointments with a Clinical Psychologist in order to be eligible to continue treatment when receiving a rebate from Medicare is impractical. When a GP refers a patient with mental health issues to a Psychiatrist, the referral is valid for twelve months. I would like the Committee to consider a similar arrangement for Clinical Psychologists please.

The procedure just mentioned is not necessary as the GP is usually guided by the Clinical Psychologist's assessment and treatment recommendations. I find most patients want to overcome their problem/s and complete treatment as soon as is practically possible. The current system that requires the patient to obtain a Mental Health Review after six sessions is redundant. Most of my 'severe' level patients require the full 18 sessions (and more). I have often been intrigued as to what empirical research was used to the guide the policy that the referring GP would be the one to determine a patient's eligibility for ongoing treatment with a Clinical Psychologist?

**(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;**

As Clinical Psychologists are required to work according to sound empirical principles, I am dismayed that no sound reviewed research has been provided about how the decision has been made to reduce services to mental health patients.

The provision of Clinical Psychology services in private practice is a very cost-effective method of funding treatment to a wide section of the community. It is common for private practitioners to consult with 5-8 patients each working day. The Australian Psychological Society recommended fee for a 50 minute session is \$212. The Medicare bulk-bill rate is \$119.80 (for a Clinical Psychologist) and is an economical method of patient treatment. From this cost the practitioner is then required to pay tax, room rental or mortgage repayments, superannuation, make provision for holiday & sick leave, secretarial and all office running expenses. As such, the rate the private practitioner eventually "takes home" can be substantially less than his/her Government employed colleagues who have all of these expenses covered in their salaries.

My reason for mentioning these figures is that the amount that the Government currently spends on Medicare rebates for mentally ill people is comparatively small in comparison to the overall cost of patients who remain on Centrelink & other benefits long term due to their mental illness. I have had patients return to fully functioning lives, including employment, due to the combined treatment from private GPs, Psychiatrists and Clinical Psychology that may have otherwise not have occurred as the individuals were not eligible for public community mental health services. The cost saving in these situations is virtually incalculable.

**(c) the impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program;**

The ATAPS application form in the region where I have my private practice requires applicants (for provision of clinical psychology services) to answer questions to a hypothetical scenario that is then evaluated by someone in the Division of General Practice to determine whether the applicant is suitable! It seems this particular Division of General Practice did not base their application on any sound empirical research or have any regard for the qualifications required and registration process of Clinical Psychologists.

Perhaps the Committee might like to review the process by which ATAPS applications are assessed and recommend a unified approach to contracting sessions with Clinical Psychologists who are skilled in the area of assessing and treating mental illness.

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

I would welcome a more comprehensive system for ensuring coordination of treatment and flow of information for patients with severe mental illness. I have had some patients referred with a minimum of information subsequent to their admission to and discharge from an inpatient mental health ward of a public hospital. The current referral procedure requires the patient to have a Mental Health Plan from their GP in order to obtain Medicare funded appointments with a Clinical Psychologist. It would be more efficient if a referral could be made directly from the inpatient ward, including a comprehensive discharge summary of the patients assessment, diagnosis & treatment and that a hospital-generated referral from a medical practitioner be mandated as valid for Medicare rebates for a Clinical Psychology. This would help to overcome (a) any break in communication about the patient's history, and (b) collaboration by all parties in the event that the patient requires a re-admission to an inpatient mental health ward.

**(e) mental health workforce issues, including:**

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

It is imperative that if Medicare continues to fund treatment with general level (ie, Bachelor degree level) Psychologists that the two-tier system remains in place. My reasons are outlined in point (ii) in the following paragraph.

**(ii) workforce qualifications and training of psychologists, and**

The Masters and Doctoral level of training in Clinical Psychology is a rigorous journey in psychological theories, psychopathology assessment & diagnosis, life-span development, psychometric assessment and empirically based treatment methods plus conducting original research and submission of a thesis for independent examination. The depth of studies undertaken during the 2-3 years full time equivalent takes students far beyond the skills of the basic undergraduate degree - usually a Bachelor of Psychology or a Bachelor of Arts (Honours) in Psychology. The competition to gain entry into the Masters and Doctoral training programs is steep and only a small percentage of applicants are offered a place in the program. Once in the program, trainees have to consistently demonstrate ALL aspects of professional and personal conduct fitting with those needed in this profession.

The level of training in Australia to obtain registration as a "Psychologist" is not only (i) the lowest level in the Western world, but also (ii) does not permit registration as a psychologist in any other country. In fact, those who have a clinical Masters degree in Australia only qualify for registration as a "Clinical Psychologist" in the UK and Ireland. In the USA and Canada, a doctoral level qualification is required to call oneself a Psychologist.

My support of the two-tier system is to acknowledge the higher level of skill and training of Clinical Psychologists. My view is also based on 17 continuous years of supervising both clinical masters and/or doctoral students as well as new graduates. In both cases each requires intensive surveillance and assurance of quality assessment and intervention. Given that, in most cases, only the highest calibre of applicants are accepted into the clinical training programmes. These intelligent and caring trainees still require close supervision and guidance to ensure they have sufficient skills to work with people with severe and/or chronic mental health problems. I have observed directly many inexperienced trainees assessing and interviewing patients with mental

health problems. I have observed and supervised trainees who are early in their clinical training as well as those who are close to completion. There is no doubt that their knowledge and professional development with a post-graduate degree is markedly greater than their undergraduate colleagues. The two year full time work and supervision experience that is required beyond the Masters / Doctoral training is essential to cement these skills.

**(f) the adequacy of mental health funding and services for disadvantaged groups, including:  
(i) culturally and linguistically diverse communities,**

There is no provision for those of us who work in private practice to have access to accredited interpreters unless either the Clinical Psychologist or the patient is willing to pay the fee. Australia is fortunate to have an excellent range of NATI accredited interpreters who would be an excellent support in private practice. I have worked with interpreters when undertaking assessments in hospital settings without whom the assessment and treatment would have been impossible. Thus, in private practice, provision of services is restricted to English speaking patients unless the Clinical Psychologist is fluent in another language.

**(g)** I am unable to comment on this point.

**(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;**

I do not know of any sound research about best practice in delivering services on-line. However, it is an area of much needed research. Suffice to say that there are people still alive today thanks to the over-the-telephone supervision I received from skilled city colleagues when working as the sole Clinical Psychologist in a very remote region of Western Australia the late 1980's and early 1990's. I only imagine how much more supported I would have felt had the internet option been available during those years.

The provision of on-line services will inevitably develop and would be an excellent PhD project to assess and recommend the use of Skype and other real-time face-to-face via the internet supervision, assessment and treatment. One method of attracting a suitable applicant is to make such research a salaried position and perhaps incorporate this into the 'national mental health commission' that was one of the other Terms of Reference upon which I did not comment.

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Clinical Psychologist**

**Notes**

1. The research on anxiety, its origins and treatment methods are too numerous to list. However, if the National Committee wishes to review the webpage for Dr David Barlow of Boston University, it will be immediately apparent that this condition is serious. Dr Barlow's site also includes co-publications with the esteemed Australian psychology researcher, Dr Ron Rapee:

<http://www.bu.edu/anxiety/dhb/journalpublications.shtml>