Commonwealth Funding and Administration of Mental Health Services

To whom it may concern;

I am writing to express my concerns regarding the Commonwealth Funding and Administration of Mental Health Services.

I am strongly concerned regarding the reduction, under the new budget, of the number of psychological treatment sessions provided under the Better Access scheme from 6 to 18 sessions to 6 to 10 sessions per calendar year. It is unclear on what basis this decision was made, as no evidence was cited supporting the reduction in number of sessions. Although I applaud the government's desire to spend more money on mental health, the increase in funding to services such as ATAPS has come at the expense of funding to Better Access.

For most mental health disorders, best practice is to deliver psychological treatment in 10 to 20 sessions. Psychological treatment allows people to achieve significant, long-term changes. Limiting the number of sessions to 10 will allow psychologists working under Medicare to provide only education and brief interventions. I work as a clinical psychologist registrar both in private practice and in the public health system. In my experience in private practice, clients who receive psychology services for more than 6 sessions are generally clients with complex presentations, having moderate to severe mental health conditions complicated by other factors, such as a history of trauma, alcohol or drug use, multiple mental health problems, and relationship stress. Most clients will not continue treatment after improving their symptoms to a manageable level. According to a 2010 review, only 5% of patients received 13 or more sessions in 2008. By eliminating the funding for more than 10 sessions with a psychologist per calendar year, the government is punishing those who need help the most.

Working with clients whose presentations were severe enough to be admitted to a psychiatric hospital, I have found it is often difficult to arrange psychological follow-up for people with complex conditions. The community teams are almost always over-stretched and poorly resourced. Psychologists working in community teams are often limited to case management due to the number of clients they are required to see. Our best solution for those who were able to follow through with appointments was always to refer people to receive psychological therapy with a clinical psychologist under the Better Access scheme. With these changes, I worry that this will affect our ability to discharge people from hospital, and also affect the rate at which people are re-admitted when they find that they are unable to cope with their symptoms once they are living at home.

People receiving psychological treatment are able to improve significantly in their symptoms, which we assess through a number of tools. The provision of psychological services often results in better outcomes, such as returning to work or school, being able to continue to care for children or adults at home, improved

physical health, etc. This may translate to financial savings in terms of reduced consumption of services as diverse as Centrelink benefits, Community Services care and monitoring, and public hospital stays. Better Access to Mental Health has allowed Australians at all income levels to see a psychologist and receive evidence-based treatment for mental health disorders.

Psychological services provided under Better Access are more cost-effective than those provided under other models such as ATAPS. The government is able to avoid administration costs (e.g., rent) and deliver psychological services cheaply and effectively through Better Access. Under ATAPS, the mental health consumer has a limited choice of service providers and may be seen as part of a "team-based approach" by workers from various professions providing Focused Psychological Strategies instead of by a clinical psychologist providing individualised, evidence-based therapy (e.g., CBT) targeting their specific problems. Under the new budget, people with more serious presentations are expected to receive services under ATAPS. However, there is no logical reason why people with *more* complex, serious mental health conditions should receive treatment from professionals with *less* training in the assessment and treatment of psychopathology. The other alternative is to receive services from a psychiatrist, but there are limited numbers of psychiatrists in private practice, particularly in lower-income and rural areas, and even fewer who can bulk-bill patients.

With regards to the rationalisation of GP mental health services, I understand that a large portion of the costs for Better Access was incurred through reimbursing GPs for writing mental health care plans. I would suggest that it would be sufficient for GPs to provide a simple referral letter to a clinical psychologist as they would to any medical specialist. Indeed, some clients report that they have had difficulty getting a referral from their GP; some GPs apparently find the production of a mental health treatment plan onerous. It would actually be irresponsible for clinical psychologists to rely on the GP's treatment plan, as they have been trained to assess, formulate, and design their own treatment plans. Eliminating the GP-provided mental health care plan for clinical psychologists would simplify and streamline what can already be a difficult process for people who are experiencing psychological distress.

The two-tiered Medicare rebate system should be retained. Employers, both public and private, recognise the value of accredited post-graduate training in clinical psychology. In order to be endorsed as a clinical psychologist, the psychologist must complete 6 years of university training (4 years undergraduate plus 2 years in a Master's program) plus 1 to 2 years of supervised practice and continuing education. A Master's in clinical psychology is entirely focused on evidence-based specific training in assessment, diagnosis, case formulation, and therapy for mental health conditions; it includes components of theory, practice, and research. Almost all master's students intern within their respective university psychology clinics, which require a rigorous assessment of their assessment, diagnostic, formulation, therapeutic and report-writing skills. Undergraduate training in psychology is purely theoretical and provides a broad overview in all areas of psychology, but no specific

clinical skills, and no internships, placements, or practical work. Generalist psychologists complete an additional two years of supervised placements, but no coursework, exams, or research to strengthen their skills in evaluating evidence-based practice, and no independent assessment of these skills. Australia is the only industrialised country that maintains this system of allowing registration as a psychologist with only an undergraduate degree. Australia has existing standards for the quality and rigor of graduate-level (professional) psychology training through the accreditation process. If there are concerns for the qualifications of psychologists, a solution would be to end the generalist registration program and require all newly registered psychologists to have achieved a minimum of Master's level training, as is the case in other countries.

Recommendations:

- Reverse the changes to Better Access, allowing people with mental health problems to access 6 to 18 sessions per year.
- Eliminate the need for General Practitioners to write Mental Health Care plans to clinical psychologists
- Retain the two-tiered system of Medicare rebates
- Phase out the generalist psychologist registration pathway.

Thank you for the opportunity to make this submission.

Sarah Mithoefer