Dr. Lisa Kettler
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Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600
Australia

Dear Reference Committee Members,

RE: Senate Community Affairs Reference Committee Inquiry into Commonwealth Funding and Administration of Mental Health Services.

As an Australian citizen and a Registered Psychologist, with specialist endorsement in Clinical Psychology, I am writing to express my deep dismay and strong objection to proposed changes to the *Better Access to Mental Health Care Initiative* (*'Better Access Initiative'*) as announced in the 2011 Federal Budget. I am an experienced clinical psychologist (Registered and practicing since 1993) and I am also a Senior Lecturer contributing directly to the undergraduate and postgraduate training of Clinical Psychologists at the University of Adelaide. I have recently commenced a position as Director of Training at the new GP SuperClinic at Playford North, on secondment from the University of Adelaide. I am making this submission to the Committee as I am deeply disappointed by a number of aspects of the proposed changes which fall under this committee's Terms of Reference. Please be aware that I make this submission as a private citizen. My views are informed by my training, experience and current employment, but I make no claims that these views are in any way intended to represent the views of my employer. Two points within the inquiry's Terms of Reference are the focus of this submission and are addressed separately below.

1. **That from 1 November, 2011, the yearly maximum allowance of sessions of psychological treatment available to people with a recognised mental health disorder will be reduced from 18 to 10 sessions.**

I believe this proposed change has potential to do real and significant harm to some of our community's most vulnerable people, by denying them access to appropriate continuity of care and sufficient service provision. Despite the flaws in the recent evaluation of the Better Access program, there is at least preliminary evidence of the value of the program in its current form, little if anything to suggest that practitioners are "over-servicing" the population and clear evidence that the program is meeting previously unmet need in the community.

.As a clinical psychologist, I am committed to excellence in service delivery and to the application of evidence based interventions. It is important for the committee to be aware that the research literature demonstrates quite clearly that between 10 and 18 sessions are often required to deliver quality, evidence based individual CBT or IPT interventions even for single diagnoses, and relatively uncomplicated case presentations, in

randomised controlled trials in University settings. Complex co-morbid and longstanding mental health issues regularly require longer and multi-faceted treatment in order for lasting change to be achieved and for the intervention to be successful. Complexity is important here as clinical psychologists in particular, who are providing services under the Better Access scheme are not only providing services to individuals with mild to moderate mental health problems or single diagnoses; they are often working with multi-systemic problems of substantial duration and complexity.

My passion for retaining the current system arises from both broader conversations with my professional colleagues about best practice care and from the context of my own clinical work and experience. My most recent practice has been in two private bulk-billing GP practice settings in low socio-economic areas od Adelaide (Craigmore and Munno Para West). These suburbs both fall within one of South Australia's areas of highest assessed burden of mental health concerns, and greatest need in terms of limited access to services. As a small example of the level of need in the community, with referrals generated from GP's in only one mid-sized practice in Craigmore, SA between 2007 and 2010, and capacity to practice on only one day per week in addition to my university role, I rapidly found myself with a case-load of up to 30 active cases at any given time and more than 50 referrals on a waiting list with distressingly long waiting times for a first point of psychological care.

While a modest subset of these clients presented with relatively uncomplicated concerns and could be offered effective treatment within 6-10 sessions, the majority of clients in this setting presented with moderate to severe mental health problems and comorbidities of a longstanding nature, requiring at least 12 sessions of treatment to stabilise and at times the additional 6 sessions available under exceptional circumstances. For the most complex cases, including those with personality disorders and highly chaotic personal circumstances, where effective work could not be completed with even 18 sessions, there was careful planning involved to stretch out session timing in order to "see people through" to the next calendar year when they would be eligible for re-referral under a new plan. This was not the product of ineffective care. The clients were making good progress under their psychological care, GP's were highly satisfied with the progress shown by their clients and often, substantial gains were being made against very difficult and entrenched problems.

For many clients in this practice setting, mental health concerns were overlaid with complex family circumstances, poverty, unemployment, chronic disease, substance misuse or dependence and histories of either domestic violence or abuse in childhood. Many clients were also struggling with carer duties for relatives with disabilities and /or social isolation and some were struggling with significant ongoing legal matters before the courts. Ideally, clients with these sorts of presentations would receive services from public mental health systems. These people were, however, not being seen by public mental health services and even when referred on to public services due to the complexity of their concerns, often reported being unable to access those services due to transport issues or longer waiting lists than my own lengthy waiting time. The majority returned to their GP and expressed a strong preference for care under Medicare psychology services. Working with this population to achieve successful outcomes takes time.

In my clinical experience, complex psychological work of this nature can be undertaken successfully under the existing *Better Access* Medicare arrangements. However, I am deeply concerned as to how much those treatment outcomes will be adversely impacted if the funding for the *'Better Access Initiative'* is effectively halved (18 sessions to 10 sessions per annum) as it implies that the same treatment outcomes can be achieved with half the amount of sessions. It is unrealistic to expect individuals in a highly vulnerable psychological state to immediately establish a rapport with a mental health professional, have all of the pertinent issues discussed,

and understood (especially for individuals who regularly present in crisis) and for active interventions to have been implemented and integrated into a client's daily life even within the current 12-18 sessions. – let alone achieve treatment gains within 10 sessions.

To use an analogy, cutting psychological therapy short is a bit like stopping a course of antibiotics as soon as a person starts to feel better; we know this is a bad idea as it can lead to antibiotic resistance and poorer health outcomes. The same is true for psychological therapies – lasting gains are not made by patients unless a sufficient "dose" of therapy is received, and the patient can experience distressing recurrence of problems, that could have been averted with adequate treatment in the first place. I'm sure I do not have to point out the obvious financial implications of the need to re-treat. The psychologist is the person in the best position to determine, in collaboration with the patient and the GP, whether an adequate dose of therapy has been received. As with many medical interventions, doses required by different patients can vary widely within reasonable limits. An upper limit of 10 sessions is not reasonable! Likewise, the notion that the primary care psychologist will do some initial work and then refer a patient with complex needs on to other services, completely minimises what the experience of psychological therapy and engagement with a psychologist is like for the client. Psychological work requires the development of a relationship with the provider, often around highly sensitive, distressing and difficult subject matter. The last thing that most clients want or need, once rapport has been established with a provider, is to be told they will need to go through the process all over again with a new practitioner when the sessions run out. There is no doubt that some clients will benefit from additional services from other allied health providers, but rarely at the expense of cutting short an existing program of effective treatment. The proposed cuts to the *'Better Access Initiative'* reflect the Federal Government's lack of understanding of the specific and varied needs of Australians with mental health disorders.

I urge the committee to reject these proposed cuts immediately and instead maintain the current amount of treatment sessions available with a Psychologist under the *Better Access to Mental Health Care Initiative* .

2. **the proposed abolition of the two-tiered Medicare system for Psychologists**

This proposal is completely inconsistent with the recent establishment of areas of Specialist Endorsement in psychology by AHPRA. It would be both naïve and disappointing for the committee to accept the view that at least two years of additional nationally accredited training makes no difference to either the quality or complexity of care that can be undertaken by psychologists, and further, to take the view that the additional level of specialist skill that can be provided by a specialist clinical psychologist has the same monetary value as the service provided by generalist psychologists.

Clinical Psychology requires a minimum of eight years training. Practitioners must complete a four year undergraduate program of study in psychology, two years of formal, nationally accredited postgraduate education in clinical psychology and two years of supervised independent clinical psychology practice under the supervision of a specialist clinical psychologist before being eligible for specialist endorsement. And rightly so, when we will be called on to offer effective, evidence-based services to the most complex of clients and mental health presentations. Clinical psychology is the only profession, apart from Psychiatry, whose entire accredited and integrated postgraduate training is specifically in the field of lifespan and advanced evidence-based and scientifically-informed psychopathology, assessment, diagnosis, case formulation, psychotherapy, psychopharmacology, clinical evaluation and research across the full range of severity and complexity. We are well represented in high proportion amongst the innovators of evidence-based therapies, NH&MRC Panels, other mental health research bodies and within mental health clinical leadership positions.

I am in a valid position to comment on the impact of additional training in clinical psychology, having been directly involved in training and mentoring of clinical psychologists at the University of Adelaide for the past eight and a half years. During this time, substantial numbers of our incoming postgraduate clinical psychology students have been already registered psychologists. Many of these practitioners return to study specifically because they are seeking a broader and deeper knowledge base and specific skills in clinical psychology than they have been able to develop as a result of their supervised pathway to practice and subsequent practice and professional development experience. There is no doubt that psychologists with a generalist training have a solid set of core competencies, and as one would hope, on entry to postgraduate training, they often demonstrate more advanced competencies in some areas than other trainees in the program. It is also true however that on completion of the postgraduate program, these practitioners typically report that their postgraduate training offers them very substantial new learning, significantly increases their skill, sophistication and confidence in clinical psychological theory, thinking and practice and delivers the balance and depth of training in clinical psychology that their previous pathway did not. These are of course the skills required to deliver high quality specialist clinical psychology care.

The treatment of clients presenting with mental health problems in the moderate to severe range is the unique specialised training of the Clinical Psychologist and, to undertake a comprehensive treatment of these individuals, more than thirty sessions per annum are sometimes required. In this way, Clinical Psychologists should be treated as Psychiatrists are under Medicare as both independently diagnose and treat these client cohorts within the core business of their professional practices.. Given the government imperative to cut costs, however, it is unlikely that the current review process will result in an increase in the current number of sessions available to psychologists. Thus, at minimum, I believe that the decision to remove the two-tiered system for psychology, along with the decision to cut session numbers for the specialist clinical psychologist Medicare items, should be reversed immediately.

I would go further in the debate about the two-tiered Medicare system to say that instead of abolishing the current two-tiered system for psychology, and assuming that a generalist trained psychologist has the same skill set as a specialist and does work of the same complexity and value, further work should be put into recognising the added value of care provided by other specialist psychology groups, and establishing appropriate levels of payment for other Medicare relevant psychological specialties. Education of medical practitioners about the specialist knowledge, skills and areas of practice of psychologists from different specialist areas may help to streamline the referral process for patients with more complex needs and improve treatment outcomes.

Thank you for taking the time to consider this submission. I sincerely hope that the committee members find the information and views provided herein of value in their deliberations.

Yours sincerely,

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