SUBMISSION TO SENATE INQUIRY INTO MENTAL HEALTH SERVICES

Submission by Don Tustin PhD in Psychology

Clinical Director

SUMMARY

This submission focuses on provision of therapy for two groups of people, families with complex needs, and people who are severely affected by a mental illness.

Families with complex needs are families where a parent has a mental illness, children have a behavioural disorder, and the family experiences tension arising from appearances before a Family Law Court. The submission proposes that families with complex needs require ongoing access to 18 sessions of therapy per year under the Better Access scheme to address the range of issues that arise. The submission argues that current shortcomings arise from deficiencies in state services that are better remedied by providing direct access to skilled therapists rather than by introducing a new group of case-coordinating administrators.

The second topic involves a definition of level of severity of a mental health condition. It is proposed that severity be assessed using three categories instead of the current two categories, and that severity of condition be assessed in terms of actual and potential use of expensive hospital services. Assessing severity in terms of use of services permits an analysis of the cost-effectiveness of alternative interventions. A stepped system of care can be introduced where less expensive interventions are used before more expensive interventions.

The submission proposes that service delivery by the commonwealth government become client-centred rather than therapist-centred by focusing on level of client need rather than on qualification of therapists.

The submission outlines the author’s experience in providing therapy for clients. Statistics are given to show that clients with moderate difficulty have been supported successfully by private practitioners using the current 18 sessions of therapy per annum, and that additional sessions have not been required in the following year. It is argued that the proposed brokerage system for people with severe conditions is less cost-effective for many clients than providing clients with direct access to skilled therapists. New methods of accountability for skilled therapists are proposed. It is proposed that many clients with severe conditions can manage their own services and do not require the assistance of expensive case coordinators.

SUBMISSION

This submission provides background information and addresses the following terms of reference:

B4 – Impact of changes to number of allied health treatment services for people with mild and moderate illness

C – Impact and adequacy of services provided through the Access to Allied Psychological Services ATAPS

D – Services for people with severe mental illness and coordination of these services

E1 – Impact of two-tiered Medicare rebate for psychological services

E2 – Workforce qualifications and training of psychologists

F – Adequacy of funding for disadvantaged groups

G – Role of National Mental Health Commission

J – Any other related matter

BACKGROUND

I focus on two groups of clients:

- Families with complex difficulties including mental illness in a parent, some behavioural disorder in a child, and tension within the family arising from separation of parents and appearances before a Family Law Court
- Adults with moderate/severe mental illness who attend emergency departments of hospitals and who may require admission to hospital if adequate community supports are not available

I consider that clinical psychologists are trained to deal with complex cases including those above, and that therapists require ongoing access to up to 18 sessions of therapy per year if they are to be cost-effective in their work with complex cases.

Family issues

I have previously worked in a state mental health service in Noarlunga South Australia where a third of clients were parents with episodic mental illness who cared for dependent children, often as single parents. I over-sighted a Parent Assist program that minimised hospitalisation of parents with mental illness and reduced the need to place their children into the care of the state child protection service.

I now work in a group private practice of psychologists where clients are referred under the Better Access scheme. I continue to support parents with episodic mental illness in caring for their

children, but this commonly requires up to 18 sessions of therapy in the first year following referral to deal with the multiple issues that arise. Many clients have appeared before either a Family Law Court or the Youth Court where they are viewed as complex cases. I have intervened as a private psychologist in complex cases and have achieved outcomes where both of the separated parents continue to participate in a shared parenting role, although initially there was a significant risk that parents would become dysfunctional and that children would be placed into the care of the state child protection service.

I use a Parenting Capacity Screen to assess ability of parents to meet the needs of their children. This is a screen based on international research that is adapted to standards in Australian legislation.

This submission argues that continuing a maximum of 18 sessions of therapy per annum will enable clinical psychologists to support parents with complex needs, whereas the proposed reduction in number of therapy sessions will result in many children being placed into state care because their parents are unable to overcome their personal difficulties sufficiently to be able to focus on meeting the needs of their children.

Moderate or severe mental illness

I worked for over ten years in a state community mental health service in Noarlunga that served the Council of Onkaparinga which has a population of about 160,000 people whose demographic profile is similar to the rest of Australia. I was Team Leader of a multi-disciplinary team with an initial staff of about 30 professionals. Staff resources were re-allocated both to meet the varying needs of adults with mental illness, and to coordinate service provision with other health and welfare teams in the local community.

It is a difficult task to organise and to administer community mental health services. A community mental health service needs to have joint aims of providing adequate supports to a range of clients and family carers with varying needs, while minimising disability and ongoing dependence on government services. I consider it wise to adopt a bias of assuming that clients are capable adults who are able to recover from their illness and to manage their own affairs until the contrary is proven, so as to avoid introducing expensive administrative processes that produce unnecessary ongoing dependence by clients on government services.

Over time, staff in the Noarlunga Community Mental Health Service were allocated into *four* main programmes to meet client needs, as follows:

- An **Emergency team** that was the first point of contact for members of the public.
- A **Therapy team** that supported registered clients for about one year with most clients then being discharged with a minority being transferred to a continuing care team. The aims of the Therapy Team were to teach self management skills to individuals, to promote support skills from family carers, and to minimise hospitalisations. The therapy team included three specialised programs: (a) an Early Psychosis program based on the EPPIC model operated by Professor McGorry, (b) a Parent Assist programme that supported parents with a mental illness who had dependent children, and (c) a program for clients who frequently presented in crisis with anxiety complicated by borderline personality disorder (BPD). The Early

Psychosis program supported about 10% of registered clients, the Parent Assist program supported about 15% of clients, and the BPD programme supported about 5% of clients.

- A **Continuing Care team** supported people whose mental illness produced significant disability with low prospects for full recovery from their disability, and who experienced periodic relapses. These clients were supported by one key worker, and often were assisted by a disability support worker to conduct practical tasks such as shopping, paying bills and socialising. The Continuing Care team supported about 35% of all registered clients.
- A **Mobile Assertive Care team** supported clients whose mental illness was less stable and who were regularly attended by two staff to minimise various risk issues. The Mobile Assertive Care team supported about 10% of all registered clients.

All community mental health staff had access to cars and made assertive home visits as many clients were not reliable attenders at appointments, and clients could relapse if their medication was not maintained. This criterion of reliability of attendance differentiates clients who can and cannot be supported by private practitioners.

Staff came from multi-disciplinary professions. Clients in the Continuing-Care and Mobile-Assertive-Care programmes received the more expensive case-management service where decisions about the allocation of services were made by a case manager. Clients in case-management programmes required the close coordination of three types of service: medication, therapy, and practical supports. In the clinical case management system, a professional with qualifications in a mental health discipline provides some services and refers clients to other agencies to obtain services such as budgeting advice and recreation. In a brokerage system, the case-coordinator does not provide clinical services but makes decisions about service allocation and pays for services.

Clients in a Therapy programme were commonly supported by two professionals who provided therapy and medication respectively. Therapy was provided to all clients and therapy often assisted in promoting recovery and in reducing level of long-term disability. Therapy was offered as an initial intervention rather than as an intervention of last resort.

A team approach where several staff assisted each client was provided by the Emergency, Early Psychosis, Continuing Care and Mobile Assertive Care programs due to the pressure placed on individual staff by client and family issues. In my view, these programmes need to be coordinated by a state government service and cannot easily be delegated to non-government agencies or to private practitioners due to the *very high complexity* of client and family needs.

On the other hand, most therapy services can be provided by private therapists, including therapy for an intact family.

Most clients who received therapy were not supported by the Disability Support Pension (DSP). On the other hand, most clients who received a case management service did receive a DSP. One aim of therapy was to minimise ongoing reliance on government services including the DSP.

In all programmes, service provision was reviewed annually, and a review could lead to a client being discharged from a program to mainstream services that were over-sighted by a GP or to a client being transferred between programmes.

I participated in an evaluation of the continuing-care program in a joint venture with the Southern Division of General Practice entitled "Collaborative care in mental health in Noarlunga. " This evaluation supported the continuance of the programs outlined above.

I subsequently moved to run a group private practice in the western suburbs of Adelaide where therapy for a large proportion of clients is funded via the Better Access scheme. I have continued to provide services that can be delivered by a single therapist operating from a community base. The group practice has attracted experienced and skilled psychologists. The main criterion for accepting referrals is that the client is reliable in attending appointments, and acceptance is not restricted to low prevalence conditions. I work full-time in providing therapy and I have been audited as one of the top 1% of providers of psychological services who made claims for Medicare benefits.

B4 – Impact of changes to number of allied health treatment services for people with mild and moderate illness

When first introduced in 2006 the Better Access scheme allowed clients to receive 12 sessions of therapy per year in two sets of 6 sessions as authorised by a GP, with a possibility of receiving an additional 6 sessions under an exceptional circumstances clause to make a maximum of 18 sessions. While the term 'exceptional circumstances' was not well defined, it was understood to refer to people with complex needs.

The recent Budget recommended reducing the number of psychological therapy sessions provided under the Better Access scheme from a maximum of 18 to a maximum of 10 sessions per year. The Budget papers stated a plan to re-design the Better Access scheme to focus on people with common mental health disorders of mild to moderate severity (high prevalence conditions of anxiety and depression). The Budget stated a plan to adapt the ATAPS scheme that is administered by Divisions of General Practice to provide case facilitators to cater for the needs of people with a severe condition who were hard to reach under the Better Access scheme by brokering service delivery.

Service delivery systems for Severe disorders

When the Better Access scheme was introduced in 2006 there were no diagnostic restrictions on client eligibility, with the World Health Organisation ICD-10 used to identify eligible conditions. Low prevalence diagnoses of schizophrenia, psychosis and bipolar disorder were all eligible. Clients with low prevalence conditions have been referred to our group practice as well as clients with high prevalence conditions of anxiety, depression and substance abuse.

An evaluation of the Better Access programme by Pirkis 2011 notes that the Better Access program is "providing treatment for people who have severe symptoms and debilitating levels of distress." Pirkis found that 93% of Better Access clients had a common or high-prevalence condition (affective, anxiety or substance use disorder) and the remaining 7% of clients had a more complex condition. Pirkis found that 80% of clients had a severe disorder, and that 45% had a high level of disability, with 28% having taken 7 days "out-of-role" in the 30 days before referral. About 13% of clients received additional sessions under the exceptional circumstances clause. This evaluation

demonstrated that the Better Access programme is capable of supporting people with severe conditions.

In contrast, the 2009 Post Intervention Review (PIR) introduced the idea that the Better Access scheme was designed to provide only short-term intervention for common or high prevalence conditions such as anxiety and depression. The PIR report expressed the opinion that conditions that complicate the treatment of anxiety and depression (such as personality disorder, complex family relationships, and pain arising from physical health conditions) are not eligible within the scope of the Better Access guidelines. The PIR report used only two categories to describe people with mental health conditions; mild-moderate and severe. The authors of the PIR considered that the Better Access scheme was not intended to provide care for complex and chronic cases, and so did not recommend changes to make the Better Access scheme more cost-effective in supporting those people with complex needs who benefit from therapy.

In my opinion, the view of the PIR is controversial and if implemented will continue the tradition of disadvantaging people with complex needs, ignoring evidence that the Better Access scheme was able to support people with complex mental health needs when clients were referred for therapy from an appropriate psychologist. An alternative approach permits suitable clients with complex needs to remain eligible for support from a single therapist under the Better Access scheme, and to continue to receive additional sessions of up to 18 sessions per annum under the exceptional circumstances clause according to the judgment of the client's GP. In my experience, GPs are skilled in administering the exceptional circumstance clause to ensure that additional therapy sessions go to people with complex needs. There are many people with complex mental health needs who are still able to make their own decisions and to manage their own care, and who do not need to be diverted into a more expensive case coordination system as proposed in the Budget papers. It will be cheaper and more cost-effective to provide additional sessions of therapy from a skilled practitioner than to add a new component of case coordination for all clients with complex needs.

It is noted that if clients with a severe condition are referred to a psychiatrist then the client becomes eligible for 50 sessions with each session being at a higher cost to the taxpayer.

Classifying levels of severity

A better system for providing mental health services will be developed if severity of mental health conditions is classified into *three* rather than two categories. Three categories of severity can be distinguished according to the number of therapy sessions required as follows: *mild* if a client can be managed using ten sessions, *moderate* if a client requires additional sessions from a community based therapist, and *severe* if a client requires close coordination of a range of support services delivered by a team of providers.

Summary

In summary, the 2006 Better Access scheme allowed clients with complex needs to access up to 18 sessions of therapy per year if exceptional circumstances applied. Clinical psychologists are trained to provide cost-effective therapy to clients with complex conditions. A distinction can be made between clients with *moderately complex* needs who can be supported by a single skilled therapist

who has access to additional sessions, and clients with *severe* needs who require support from a multi-disciplinary team of professionals operating from one base.

It is recommended that the current two-category of severity of mental health condition be replaced by three levels of difficulty (mild, moderate and severe).

It is recommended that the provision for 18 sessions of therapy be maintained for people with moderately complex needs where therapy is provided by a clinical psychologist.

It is recommended that a mechanism be introduced to ensure that the cost-effectiveness of additional sessions of therapy for people with moderately complex needs be monitored through periodic reviews by a clinical psychologist peer who has appropriate skills.

Our experience in providing additional sessions

Our clinic regularly reviews the allocation of sessions to clients. The mean number of sessions provided to clients referred to our clinic in the 18 months from July 2007 was 6.1 sessions. Requests for additional sessions under the exceptional circumstances clause were made for between 12% and 15% of clients each year.

Reviews showed that clients in our clinic who received additional sessions under the exceptional circumstances clause in 1997-1998 had diagnoses of: both depression and anxiety 30%, anxiety or depression complicated by a personality disorder and self harm 25%, major depression 15%, psychosis 10%, other affective disorder 10%, and 5% for each of pain and substance abuse. Of clients who received additional sessions, 15% had been hospitalised in the year prior to referral. Of clients who received additional sessions, 75% were discharged from our clinic within two years of referral. None of the clients who received additional services in 1997-98 required additional sessions in the second year of therapy, showing that intensive therapy in the first year was effective in resolving their issues.

It is noted that a number of clients who received additional sessions in 1997-98 were single parents with a mental health condition, who had been recently separated and appeared before a Family Law Court due to tension with their ex-partner, and whose children showed signs of behavioural disorder. These clients required additional sessions to deal with the multiple issues they faced. For some of these clients, notifications had been made to the state child protection service complaining that the parenting capacity of the client had been inadequate, and therapy was devoted to successfully helping these parents to overcome their personal distress and to resume addressing the needs of their child.

In 2010 a total of 35 clients received more than 10 sessions from a total of 78 referred clients, so 45% of clients received additional sessions. Diagnoses of clients who received additional sessions in 2010 were: anxiety and depression 40%, generalised anxiety 20%, psychosis 17%, depression and suicidal ideation 11%, and other diagnoses including self harm 12%. The demographic characteristics of people who received additional sessions were: 37% were recently separated parents who had appeared before a Family Law Court, 30% had complications due to personality disorder and self harm, 15% had physical health problems that produced pain, and 12% were carers

of an adult offspring with severe problems. Additional sessions were not requested for clients with mild or moderate conditions but were used to treat people with complex and severe conditions. None of these clients appear likely to require additional sessions in 2011.

Conclusion

In conclusion, our clinic has used the exceptional circumstances clause to request additional sessions of therapy for clients who have moderately complex needs and who come from sub-populations in need who traditionally have been overlooked by commonwealth and state services. Our clients have benefited substantially from the additional services made available under the exceptional circumstances clause. Our experience is that GPs are able to monitor the use of additional sessions under the exceptional circumstances clause skilfully. Clients who have benefitted from additional sessions have not required coordination of services by a case manager but have been able to coordinate their own care. Our ability to provide more intensive therapy in the initial year has helped clients to manage their own issues, and has not lead to ongoing dependence on government services.

My calculation shows that people who received a high number of therapy sessions took about 40% of my sessions, and I acknowledge that these clients have an impact on my capacity to provide services to other clients. I consider it reasonable to introduce a requirement that cases where clients receive additional sessions be audited by a professional peer to ensure that the additional sessions provide a cost-effective service for the tax-payer.

I recommend that the recent recommendation in the Budget removing the exceptional circumstances clause be revised and that an allowance for additional sessions be re-instated so that clients with moderately complex needs remain eligible for additional sessions from a clinical psychologist under the Better Access scheme, with these cases being audited by a psychologist peer appointed by the Department of Health and Ageing.

Children and families

The 2011 Budget papers propose that services for children with mental health and behavioural disorders and their families be provided through new Family Mental Health Support Centres that will operate under the ATAPS scheme administered by Medicare Locals. Service delivery will then be *coordinated* by child liaison officers who liaise between specialised mental health professionals, schools, and other children's services.

The proposal to introduce Family Mental Health Centres appears to arise from a report in 2009 by Dr Russell that children under the age of 14 years had been under-served by the Better Access scheme in 2008. However a later review by Pirkis et al 2011 found that while intake of children aged 0-14 years had been low in 2007, children in this age group had the greatest percent increase in uptake between 2007 and 2009. It does not appears appropriate to conclude that children aged 0-14 years are too difficult to reach under the Better Access scheme.

Our clinic has consistently received referrals for children aged up to 14 years, as some psychologists in the clinic specialise in the area of child and family psychology. In 2010 we received 56 referrals

for children aged up to 14 years, being 13% of overall referrals. We have found that our ability to manage the issues raised by these children is restricted, and we recommend changes that would benefit children and their families.

Under the Better Access scheme, services can be claimed only if the client is present during the session so that the psychologist "attends" the client. This emphasis on attendance permits therapy for a child, but excludes consultancy practices that are standard in the field of child psychology. In child psychology, it is common for a psychologist to provide individualised advice to parents about suitable ways of managing mental illness or behavioural disorder in their child, so it is often the parent rather than the child who is present during the session. It is not appropriate for a child always to be present while a psychologist discusses their behavioural disorder with the parent. It is also common for child psychologists to liaise with schools to obtain information from the school, to encourage teachers to develop interventions that benefit the child within the capacity of the school, and to encourage the school and family to provide a consistent approach in managing the child's condition. These two types of consultancy service (liaise with parents and with teachers) are not funded by Medicare due to the requirement of attendance.

There is a significant role for private psychologists to assist parents whose children have a behavioural disorder, as alternative services provided by state government agencies have limited mandates and the loyalty of professionals working in government departments is to the mandate of the department rather than to the parents and family. In South Australia, limited psychological services are provided by three state departments (Education, Health and Child Protection), each of which has a focused but restricted mandate. Skilled private practicing psychologists are able to provide a service that is child- and family-focused, and are able to work across sectors. There is no need for a separate case coordinator when parents are motivated to assist their child as usually occurs.

Services for children and family can be improved under the Better Access scheme if items are added to support parent education that assists children with complex needs, and to facilitate consultation between the professional and other providers including parents and schools. Provision of consultation services can be audited and monitored if a distinct item number is used.

In the past mental health services have been administered separately from physical health services because a slightly different approach is required to support people with mental health conditions. The inflexibility of Medicare has been cited in some reports as a reason to introduce an entirely new system of service delivery for people with severe mental illness through ATAPS. An alternative is to ask Medicare to show flexibility that is appropriate for people with mental health conditions.

The Budget proposes to introduce new personnel in the form of child liaison officers who will coordinate rather than provide services for families. The idea of having child liaison officers coordinate services for families is controversial as many parents are capable of coordinating services for their own child, and there is a risk that removing this responsibility from parents will dis-empower fragile parents and will increase their dependence on state services. It is wiser to provide parents with direct access to skilled therapists rather than to introduce intermediary administrative personnel as case coordinators.

There is further concern that administrative staff operating under an ATAPS scheme may restrict access to therapy services using a demand-management strategy that is based on their own criteria, as was reported in the Ninth Interim Evaluation Report of the ATAPS scheme in 2006.

It may be appropriate to introduce child liaison officers to coordinate services for those families whose problems are so severe that families cannot coordinate service delivery for their own children. This would mean that child liaison officers deal primarily with families who are deemed by state child protection services to be unable to care for their own children. Skilled family psychologists could relieve pressure on state child protection services by providing early intervention therapy for parents who are struggling but do not need the state to take over control of their children.

It is concluded that the needs of many families can be met through mainstream psychological services under a revised Better Access scheme, as the main problem in supporting children is that state mental health services have limited mandates. This is a time when the commonwealth government can re-orient provision of psychological therapy for children so that it is delivered primarily through families while aiming to benefit children. It is better to upgrade the Better Access scheme to make it more suited to the needs of children and their families, rather than to introduce new case-coordinators who are likely to dis-empower fragile families.

It is recommended that a cheaper and more cost-effective alternative to Family Mental Health Centres is to introduce a new item under the Better Access scheme for suitable therapists to claim reimbursement for providing consultancy services that include limited time spent coordinating with other children's services, for writing consultancy reports to other providers so as to coordinate treatment efforts, and to allow therapists to spend time advising the child's parents and care-givers.

C – Impact and adequacy of services provided through the Access to Allied Psychological Services ATAPS and

D – Services for people with severe mental illness and coordination of these services

The ATAPS scheme was introduced in 2001. Early reviews by the Centre for Health Policy Programs and Economics show that the ATAPS scheme initially catered for the same population as the Better Access scheme but was administered by Divisions of General Practice rather than by Medicare. Recent government documents propose that the ATAPS scheme be adapted to support clients with severe and persistent mental illness who have been hard-to-reach, and that the ATAPS scheme be administered by Medicare Locals.

Separation of service delivery systems according to severity of condition

The Budget proposes that people with a severe mental health condition will receive all services under one administration (Medicare Locals) while other citizens continue to receive mental health therapy through Medicare. Introducing a different system of service delivery for people with severe

mental health conditions requires referrers to decide which system to send a client to, a demanding requirement when no definition of severity of illness has yet been provided.

There is a significant risk that a dual system of service delivery will produce a double standard in care. At present psychologists who are qualified to provide therapy for people with complex needs (clinical psychologists) work primarily through the Better Access scheme as ATAPS schemes do not remunerate at the clinical rate. The Better Access scheme contains no incentive for clinical psychologists to work with clients who have more complex needs. The Budget proposal includes no incentive for clinical psychologists to work under the ATAPS scheme with clients having complex needs. Instead, the financial incentives provided in the Budget proposal will lead to clients with more complex needs being seen by generalist psychologists who have lower qualifications, while clinical psychologists see clients with milder needs yet receive a higher rate of reimbursement.

A better approach is to fund all clinical services (medication and psychological therapy) through the Better Access scheme, while funding case coordination and delivery of practical services for people with severe disability through the ATAPS scheme. Providing all clinical services through the Better Access scheme will avoid the risks of double standards that are inherent in having a dual system of service delivery.

As stated in section B4 above, ***it is recommended*** that the current dichotomous categorisation of severity of disorder be replaced with three levels of difficulty: mild, moderate and severe.

It is recommended that all clinical services for all clients be funded through the Better Access scheme regardless of the level of severity of their condition, and that the ATAPS scheme be used to fund case coordination and practical supports for people with severe disability.

Current financial incentives for psychologists to see people with severe conditions

The government expresses a desire that all psychologists will bulk-bill some clients. However the financial incentives do not motivate bulk-billing and it is now clear that some clinical psychologists decline to bulk-bill clients and leave group practices that promote bulk-billing to join practices that avoid bulk-billing. This decision by clinical psychologists to avoid working at the bulk-bill rate makes it more difficult for practices that do bulk-bill to attract clinical psychologists, and undermines the viability of practices that bulk-bill.

It is important for government to introduce incentives for clinical psychologists to treat clients who have moderately complex needs by changing the present system where remuneration is based solely on the qualification of the psychologist and replacing it with a new system where remuneration is based on the assessed level of complexity of the client who is seen.

It is recommended that the Better Access scheme be modified to become client-centred by providing the higher rate of reimbursement to psychologists who see clients with moderately complex needs, and to replace the current system where reimbursement is based solely on the qualifications of the psychologist.

Criterion for severity

The Budget papers propose that ATAPS provide a single process for assessing severity of mental illness, and this is beneficial. A Discussion Paper provided by the Department for Health and Ageing has proposed that severity of mental illness be defined in terms of a combination of diagnosis, intensity of symptoms, chronicity, and degree of disability. No specific definition was provided in the Discussion paper.

Another approach for defining severity of illness refers to both the range of services required and the expected outcome if appropriate services are not provided. Defining severity of mental illness according to actual and potential service-use permits an analysis of the cost-effectiveness of different interventions.

An approach based on actual and potential service provision can define levels of severity of mental illness as follows.

- People with ***mild*** conditions require only a limited number of therapy sessions and medication services, as there is no long-term disability and no use of hospital services. Services for mild conditions can be provided by professionals operating from their own base.
- People with ***moderate*** conditions require access to additional sessions of therapy, and may require temporary practical supports in addition to clinical therapy and medication to minimise disability and use of hospital services. People with moderate conditions can attend appointments and can be supported by professionals operating in community settings.
- People with ***severe*** conditions require case coordination by a professional that includes delivery of ongoing social and practical supports to minimise disability, in addition to clinical services (medication and therapy). People with severe conditions require close coordination of services provided by a team of multi-disciplinary professionals who operate from the same site.

Using the definitions above, clinical services such as therapy and medication can continue to be funded using the current Medicare system rather than through a new system. The ATAPS scheme can coordinate and fund practical supports for eligible clients.

Defining severity of services in terms of potential use of services permits comparisons between methods of intervention and facilitates evaluation of the cost-effectiveness of interventions. A cost-effective intervention is one that reduces need for more expensive services. Defining complexity of cases in terms of service usage will allow the introduction of a stepped system of service delivery where most clients start by receiving early intervention and low cost interventions and progress to more expensive services only if early intervention services have been ineffective. The stepped system of care is currently not practiced in some state services, for example, some child protection services remove children into long-term state care before providing short-term therapy aimed at assisting parents.

If severity of mental illness is defined by service use, then it is possible for Medicare Locals to administer an assessment process without being drawn into funding services that are available to

other citizens through the Medicare system. There is no need to establish a new second class of citizenship.

It is recommended that severity of mental health conditions be defined using three categories in terms of actual and potential use of services, and that delivery of practical supports be introduced via ATAPS for people with a severe condition.

It is recommended that provision of clinical services of therapy and medication continue to be provided through Medicare's Better Access scheme, while practical supports and case coordination be provided through the Better Outcome ATAPS scheme.

It is recommended that cost-effectiveness analyses be conducted of alternative systems for supporting people with severe and moderate mental health conditions based on actual and potential service use.

It is recommended that the commonwealth government promote a stepped system of care where less expensive therapy is provided first before moving clients to more expensive case coordination and placing individuals into state care.

E1 – Impact of two-tiered Medicare rebate for psychological services

Differential rate of payment

At present, Medicare has two rates of reimbursement for psychologists, with generalist psychologists receiving a lower level of remuneration than clinical psychologists. At present, the differential rate of reimbursement is based solely on qualification of the psychologist rather than on level of difficulty of the client receiving treatment.

Current evaluations of treatment of clients with high prevalence conditions of anxiety and depression have not shown any consistent difference in outcome for clients who receive therapy from a generalist or a clinical psychologist. As both the ATAPS and Better Access schemes have attracted clients with high prevalence conditions in the past, evaluations have not yet focused on the capacity of psychologists to provide safe and effective therapy for clients with more complex needs. It is likely that the more highly trained clinical psychologists have greater skills in working with clients with complex needs. It is likely to be unsafe for many lowly-qualified psychologists to provide therapy for clients with low prevalence diagnoses and complex conditions.

It would be very beneficial if the system for funding therapy to people with mental health conditions were centred on the needs of the client and on the assessed difficulty level of the client, rather than centred solely on the qualifications of the psychologist.

Level of complexity of client need can be defined into three categories as follows:

- Simple, meaning that a generalist or clinical psychologist can provide appropriate therapy within a set number of sessions
- Complex, meaning that a clinical psychologist should provide therapy, and that additional sessions may be required for effective therapy

- Severe, meaning that a case coordinator is required who can access practical supports in addition to clinical care

It is recommended that the Department of Health and Ageing adopt definitions of complexity of care for people with mental health conditions based on three levels of complexity.

It is recommended that GPs assess level of complexity of client issues into two categories that can be managed under the Better Access scheme (simple and complex), and refer cases to an appropriately qualified psychologist.

It is recommended that GPs continue to be able to provide additional sessions of therapy for clients with moderately complex needs.

It is recommended that GPs refer cases with severe complexity to the ATAPS scheme when a case coordinator is required or when ongoing delivery of practical assistance is required.

Skills to provide therapy for complex cases

Some generalist psychologists state that they have gained through experience the ability to provide cost-effective therapy for clients with complex needs, although they do not have the relevant Masters degree that is required by the professional body. At present the debate focuses on qualifications of the psychologist as assessed by the professional body, rather than on the ability of an individual psychologist to provide therapy that demonstrably helps clients with complex needs.

It is recommended that the government introduce a system for funding therapy for people with mental health conditions that is client-centred by focusing on the needs of clients, and move away from the present system that is therapist-centred as it focuses solely on the qualifications of the therapist.

It is recommended that the Department of Health and Ageing provide definitions of case complexity for mental health disorders.

It is recommended that a higher rate of remuneration go to psychologists who provide therapy for complex cases, with a lower rate of remuneration for psychologists treating simpler cases.

It is recommended that clients with complex conditions receive a higher maximum number of therapy sessions per year than clients with simple conditions.

It is recommended that generalist psychologists who claim to have the ability to provide cost-effective therapy for clients with complex needs be provided with a new avenue to demonstrate their claim, and that service provision for clients who receive additional services be subject to the same monitoring as applies to clinical psychologists who treat clients with complex needs.

E2 – Workforce qualifications and training of psychologists

The training of psychologists in Australia has both strengths and marked shortcomings.

The number of Australians who move onto the Disability Support Pension due to mental illness is rising. However it is not clear that Psychology Departments of Australian universities teach the Rehabilitation skills required to promote recovery of people who receive a Disability Support Pension.

The number of Australian families where parents divorce is high, with severe effects on children. The Australian Parliament is reviewing the Family Law Act. However it is not clear that relevant principles of Child and Family psychology are being taught by Psychology Departments of many Australian universities, or that psychologists are taught by universities to liaise with family lawyers.

The main professional body for psychologists (the Australian Psychological Society) has been influential in persuading government about structures for providing therapy, and has persuaded government to mimic its own colleges. However structures used by the Australian Psychological Society are not well matched to the needs of the population of Australia as reflected in National Mental Health Plans. The Australian Psychological Society has emphasised a need for all universities to provide uniform post-graduate training for psychologists and this has resulted in an over-emphasis on high prevalence mental health conditions while other conditions are almost ignored. The Australian Psychological Society has supported the principle that specialist areas of psychology be recognised only by the establishment of a college on topics where universities provide post-graduate Masters degrees. This emphasis on Masters degrees has lead to duplication between post-graduate courses for different colleges, and has led to some important topics being neglected.

The Australian Psychological Society has been slow to recognise gaps in services on topics that are important to the needs of the population of Australia, including topics as obvious as Family and Child psychology and Rehabilitation.

It is recommended that advice about training in psychology to meet the mental health needs of the Australian population be provided by the proposed National Mental Health Commission.

It is recommended that means be found to improve training for psychologists in the topics of *Family and Child psychology*, and *Rehabilitation psychology*.

F- Adequacy of funding for disadvantaged groups

The Budget papers identify families and children in Australia as one group of people who are disadvantaged and poorly supported by current services. The Budget papers proposed that families receive additional support through new Family Mental Health Support Centres under the ATAPS scheme. However the proposed solution may not be appropriate, as the Budget papers do not explain why families are poorly supported at present.

As stated in section B4, the problem arises in part as services for families are funded through a range of state government departments each of which has limited mandates and responsibilities. No state departments in South Australia clearly focus on providing professional support for families where parents have a mental health condition and children have behavioural difficulties.

There are current cases in South Australia where professionals from state child protection services write reports recommending that children be removed from the care of a parent before professional therapy has been provided, reflecting a principle that removing children from the care of parents is a strategy of first resort and therapy is a strategy of last resort. The manager of one state department has a policy of not providing reports to therapists who are working with family members. There is a current case where a single mother who has yelled at her two young children for fighting and who physically separated her children while fighting has been told by a child protection service that yelling is emotional abuse, and the child protection service has commenced proceedings to remove the children from the care of their mother without recommending alternative methods for disciplining the children.

It will be very beneficial to the children of Australia if the Commonwealth Government assumes a significant role in providing mental health therapy for parents who struggle to care for misbehaving children. The Commonwealth Government could introduce a policy of providing family therapy as an early intervention or as a method of first resort, and making removal of children from the care of their parents a method of last resort to be used after therapy has been unsuccessful.

Many struggling families with complex needs appear before Family Law Courts. Psychologists can assist family members who are motivated by a court appearance to improve their functioning, and a lot of progress can be made during this period. Our clinic and others assist a number of families who appear before Family Law Courts. Family Law Courts are starting to refer parents with a mental health condition for psychological therapy after viewing an initial family assessment report conducted by a nominee of the court. Therapy includes focusing on the parent's mental health condition and on parenting capacity. Therapy is funded through the Better Access scheme, often at a bulk bill rate. However there is a need to provide a treatment report to the Family Law Court and at present there is no clear source of funding to cover the cost of treatment reports. As a treatment report covers work that has been completed, the cost of providing these reports is not substantial, but nonetheless needs to be covered. There is uncertainty about whether a therapist's report can be funded through Legal Aid.

It is beneficial to provide therapy to whichever member of the family appears most receptive (parent or child), where the Better Access scheme supports therapy only for the person who is identified as the primary client. The Better Access scheme currently does not cover a psychologist advising a parent how to manage a behaviour problem of a child.

It is recommended that the best way for the Commonwealth Government to support families is to permit parents to gain direct access to skilled therapists through the Better Access scheme, rather than to add a case coordinator to tackle the task of coordinating services provided by state departments.

It is recommended that the cost of preparing a therapist's treatment report requested by a Family Law Court be covered by Legal Aid.

It is recommended that an item be added to Better Access to support family therapy for members of a family who are struggling due to mental health conditions of parents.

G – Role of National Mental Health Commission

It is proposed that the National Mental Health Commission can:

- Advise the commonwealth government about topics where the needs of people with mental illness require a different approach to the needs of people with physical illness, and encourage greater flexibility in government agencies such as Medicare when meeting the needs of people with mental illness.
- Identify approaches followed by departments of the commonwealth government that encourage citizens to develop long term reliance and dependence on government services, and promote alternative strategies that encourage responsible independence by people with mental health conditions.
- Identify topics where universities are not yet training graduates to meet the needs of the Australian population as defined in the national mental health plan, and identify strategies to provide appropriate training.

J - Other Related Matters

Publication of legal rulings

At present it is illegal to publish findings and rulings from Family Law Courts. While the prohibition on publishing rulings protects the privacy of clients, it also inhibits the education of mental health professions about the application of principles of family law.

Coordination between family lawyers and mental health professionals will be enhanced if important rulings by Family Law Courts are published in de-identified ways.

It is recommended that the Commonwealth Government commission a review of major principles and rulings made by Family Law Courts (including Youth Courts) and publish de-identified rulings in a form that facilitates education of mental health professionals about significant applications of legal principles to family functioning.

Standards of proof

At present Family Law Courts apply the civil standard of proof when considering assertions about parenting capacity, so assertions must be proven “on the balance of probabilities.” As the impact of a court removing children from the care of one parent is very significant for both parents and children, it is proposed that the standard of proof about parenting capacity applied by Family Law Courts be changed to the standard of “beyond reasonable doubt.”

At present professionals who submit reports the Family Law Courts about parenting capacity commonly do not assess the capacity of one parent against a set standard of adequate parenting, but rather compare the relative capacities of two parents. This approach of comparing relative abilities leads to recommendations to Youth Courts that children be placed into the care of one

parent without demonstrating that the capacity of the other parent is significantly lacking. There is such a strong emphasis on the needs of children that the rights of parents can be overlooked even when the capacity of the parent is quite adequate. It is not clear that Youth Courts follow the standard now expressed in the Family Law Act that it is in the best interests of children to have equivalent contact and involvement with both parents.

Family Law Courts do not provide clear legal standards for reports about parenting capacity written by allied health professionals, leaving allied health professionals dependent on guidance from state government departments. While psychologists are often asked to provide reports about parenting capacity, it is not clear that psychologists who report about parenting capacity apply the usual strict scientific standards associated with validated psychological tests. Reports about parenting capacity appear to reflect personal opinions and theories that may have little relevance to the case under consideration. While there are structured checklists relevant to parenting capacity, it is not clear that these more scientific tools are routinely used when preparing reports about parenting capacity for Family Law Courts.

It is recommended that Family Law Courts require that any submission to substantially restrict parenting rights to be based on the standard of proof of beyond reasonable doubt.

It is recommended that Family Law Courts cease to accept professional reports that describe relative or comparative parenting capacities of both parents, and instead require professional reports about parenting capacity to assess the capacity of individual parents against a legal standard of adequate parenting.

It is recommended that reports about parenting capacity provided by registered psychologists be scrutinised about the usual scientific standards of assessment that apply in psychology.

It is recommended that the Commonwealth Government encourage scientific research on tools used to assess parenting capacity.

CONCLUSION

Thank you for the opportunity to comment about this important topic of how the Commonwealth Government can reform the delivery of mental health services in Australia.

Don Tustin