Submission to:
Inquiry: Commonwealth Funding and Administration of Mental Health Services
By Tracey Jarvis Clinical Psychologist
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It is commendable that the new Federal budget is investing more in mental health. There is an urgent need to strengthen society's support for people affected by mental illness, after years of neglect and stigma.

I am deeply concerned, however, about two proposals which, if implemented, are likely to undermine the adequate provision of services for mental health. Your inquiry is considering options to:

1. scrap the two-tiered rebate system in favour of lowering clinical psychologist rates

2. wind back the maximum number of Medicare rebated psychological consultations per annum from 18 permissible annual sessions to ten sessions in a year.

In this submission, I wish to focus on why these two options are not rational and will undermine better outcomes for people and families with mental health issues.

What is a Clinical Psychologist?
As a clinical psychologist, I run a private practice in an outer suburb of Sydney. I provide assessment and treatment services for people with a range of mental health problems.

I am well trained for this role, having first completed a four year Honours degree, followed by two years of workplace supervision to qualify as a psychologist. While working as a psychologist, I applied and was chosen to study for a Master of Clinical Psychology degree. Along with course work and thesis, this required 1000 hours of clinical placement in a variety of treatment settings with children, adults and families. As I was simultaneously working as a psychologist in the field, it took me four years to complete. Then, to achieve eligibility for membership of the APS College of Clinical Psychologists, I completed a further two years of supervision by a senior colleague. In all, the journey to qualify as a clinical psychologist required more than ten years of training with very exacting measures of competence along the way.

I feel that I am qualified to comment on the issues raised by your inquiry. I have published articles in international journals on the subjects of treatment for alcohol dependence and sexual assault trauma. I have been involved in the development of national guidelines for the treatment of alcohol abuse/dependence and I am a principal author of a book on treatment methods for alcohol and drug dependence.[1] I have also provided supervision and training to other psychologists and counsellors in hospitals, rehabilitation centres, outpatient and telephone counselling services.

[1] Jarvis T.J., Tebbut J., Mattick R.P. and Shand F. (2005), 2nd Ed. *Treatment Approaches for Alcohol and Drug Dependence,* UK:Wiley & Sons.

For this inquiry to make a considered decision on the tiered rate system, it is important for them to understand the specialist skills of a clinical psychologist. The clinical training extends beyond basic training by its depth and breadth and its specific focus on mental illness and mental health. Specifically, the clinical psychologist has:

- a deep and comprehensive technical understanding of psychopathology;
- the ability to assess and diagnose mental illness in the context of an individual's psycho-social history, to form hypotheses about the factors that contribute to and maintain the illness and the strengths and supports that can be harnessed to assist recovery;
- the ability to draw on a wealth of theoretical and research knowledge, so as to implement preventative and treatment strategies in an effective and responsive way, and to evaluate progress and outcome measures;
- the skill of helping clients to have an active voice in the therapeutic process and to address issues of motivational conflict, self-doubt, and relapse;
- the knowledge of when and how to liaise with other professionals for coordinated care, including access to and monitoring of psychiatric medication;
- the ability to work with people who have complex problems such as comorbidity (more than one diagnosis), multiple traumas and/or family histories of mental illness;
- a readiness to take a leadership role in advising systems regarding professional practice, and provide training and supervision to colleagues; and
- the scientific and technical skills to implement clinical programs and undertake clinically oriented research.

Arguably, along with psychiatrists, clinical psychologists are the most well-trained professionals to provide mental health interventions in the community setting. Scrapping the two tiered system devalues the special contribution that clinical psychologists make to the mental health field. Such a decision would discourage psychologists from putting in the extra years and thereby diminish the pool of specialists - a much needed resource.

Who Seeks Help?

I understand that it has been argued that the number of rebated sessions should be reduced because clients of psychological services (a) can afford to pay without a rebate and (b) only present with mental illness of a mild to moderate range of severity.

Statistics from my practice last year indicate that these two assumptions are faulty. First, are these folks well off? Twenty-nine percent of my clients were either unemployed or students at the time of seeking help and a further 19% were in part-time work. My fees are set to cover the 50+ minutes of face to face work with each client *and* associated administrative and preparatory work such as GP review letters, case records, telephone support, professional liaison, and the preparation of personalised learning materials. For the 16% of last year's clients who were bulk billed, I had to absorb the costs of these additional tasks.

Were their symptoms mild? Of that same cohort, 31% had symptoms in the severe range; that is, their symptoms substantially interfered with their day-to-day functioning. A further 62% had moderate symptoms and only 8% presented with mild symptoms. The presenting issues included depression, anxiety disorders, post-traumatic stress disorder, grief or adjustment disorder, alcohol

or other drug abuse/dependence and personality disorders. Forty-two percent of my clients presented with more than one diagnosis. It is noteworthy that 8% had attempted suicide not long before seeing me and 3% had psychotic episodes / disordered thinking at some stage during their treatment.

The budget papers refer to the importance of early intervention. Early intervention is a key aspect of the clinical psychologist's role. Specialist treatment for people who present with mild to moderate problems can prevent their symptoms from becoming entrenched and severe. In so far as this reduces the pressure on psychiatric services, it is surely a cost-effective approach.

The Ideal Number of Sessions

It is noteworthy that policies limiting the number of sessions rebated ". . . arise without public discussion of the consequences or empirical data to justify such actions"[2]. Recent meta-analysis research[3] shows that for 50% of clients, improvement starts after 10 sessions and clinically significant changes are only observed for 50% after 14 sessions. About 70% of clients with moderate to severe symptoms only gain clinically significant results after 20+ sessions. These estimates are consistent with research from the United States.

Medicare's insistence on evidence-based methods (eg. CBT or ITP) is contradicted by the current session limit policy. In fact, the evidence indicates that if a limit is set, it is more reasonable to think in terms of 20-25 sessions and that termination before this time may disadvantage the client and "diminishes the overall value of services, especially for the most disturbed clients"[4].

This research suggests that the length of therapy be determined by routine monitoring of the client's response to therapy rather than by an arbitrary limit put in place with no reference to the needs of the client. Such monitoring is the bread-and-butter of the psychologist - particularly the clinical psychologist, who is extensively trained in methods of ongoing assessment.

Indeed, this is exactly what happens with physical illness. The person's response to the medical intervention is monitored, the treatment is adjusted and - while bulk billing is at the discretion of the medical practitioner - each intervention remains eligible for rebate regardless of the length of treatment.

Why is mental illness treated differently? What is the justification for limiting the number of rebatable sessions? Where is the evidence that this limit supports good therapeutic outcomes?

I would like the inquiry to also consider some anomalies arising from the session limit policy and the role of the GP as gatekeeper. For instance, Medicare claims that the sessions run across the calendar year. A person who is still experiencing problems after attending maximum sessions is,

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[2] Harnett, O'Donovan, & Lambert (2010), p39.

[3] Harnett, P., O'Donovan, A. & Lambert, M. (2010). The dose response relationship in psychotherapy: Implications for social policy, *Clinical Psychologist,* 14(2) pp. 39-44.

[4] Harnett, O'Donovan, & Lambert (2010), p43.

in theory, eligible to apply for a new plan in January. However, GPs are only paid to draw up a new plan at the anniversary of the previous plan. For instance, a client initially referred in July 2011 is technically eligible for another plan in January 2012 but the GP can refuse to draw up the plan until the following July. This confusion has caused real stress to clients and hampered the clinician's ability to respond to crisis and relapse.

In Summary

Mental health is so important to people, families and society that we need all hands on deck. Psychologists should be encouraged to provide services to the community. Clinical psychologists should receive additional recognition for their specialist knowledge and skills through the two-tiered system of rebate.

The liaison between psychologists and GPs assists coordinated care between professionals. However the restrictive, confusing policy of session limits by GP gatekeeper makes this coordination forced and untherapeutic. The limits are arbitrary - being neither evidence-based, nor responsive to client needs.

Medicare should be used to enable people to stay in treatment until they get better - in this, there is the question of according psychologists the same trust that is regularly accorded to medical physicians, given that we are well-trained, ethical and professional in our work. It is also a question of trusting that our clients are genuine in seeking help. And that raises questions about whether we believe mental illness is *real* illness and if so, why there is a double standard compared with the allowance of unlimited rebates for the treatment of physical illness.

Yours sincerely,

Tracey Jarvis
Clinical Psychologist and Medicare Provider.