Senate Community Affairs Reference Committee inquiry into Commonwealth Funding and Administration of Mental Health Services

community.affairs.sen@aph.gov.au

2nd August, 2011

Submission by

Susan Simpson, MPsych (Clin), DPsych.

Clinical Psychologist

Thank you to the Senate for this opportunity to address the issues raised in this important inquiry.

I am a Clinical Psychologist and Psychology Clinic Director based at the University of South Australia. I have over 17 years of experience in the field of mental health.

1) Two tier payment for clinical psychologists:

I strongly recommend maintaining the two-tier system of payment for clinical psychologists. Clinical Psychology is one of nine specialized areas within Psychology. Clinical psychology is an integration of science, theory and clinical knowledge for the purpose of understanding, preventing, and relieving psychologically-based distress or dysfunction and to promote subjective well-being and personal development.

Clinical psychology is an internationally recognized specialty of psychology in its body of knowledge and practice. The specialized training for Clinical Psychology requires six years of full-time university study and training. Clinical psychologists specialize in the assessment, diagnosis, evidence-based treatment and treatment outcome evaluation of mental health disorders across the lifespan at all levels of complexity and severity. Along with psychiatry, clinical psychology is the only specialist training in which the entire post-graduate program is in the area of mental health. This is to ensure that Clinical Psychologists have experience and knowledge in the specialist area of diagnosis, treatment and prevention of all Mental Health Disorders, identified in DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, American Psychiatric Association).Treatment interventions are drawn specifically from the scientist-practitioner model, ensuring evidence based strategies are applied. Clinical Psychologists, via an ongoing and rigorous Continuing Professional Development process, are required to ensure up to date professional development to support ongoing knowledge and competence in this specialist area.

Clinical Psychologists are considered the “therapeutic experts” of Mental Health. Whilst Psychiatrists are trained to dispense medication for mood disorders, Clinical Psychologists are specifically trained to diagnose psychopathology, provide psychological assessment, testing, case-formulation and evidenced based psychotherapy interventions and to assess when to refer to a medical practitioner for assessment and psychopharmacological intervention. We are trained to evaluate and disseminate evidence-based practice and to provide teaching and consultancies for other mental health professionals. Prior to taking up this post, I worked in the UK as a clinical psychologist for many years, where the minimum standard qualification as a clinical psychologist is a

Clinical Doctorate (DPsych). This is in fact a 3 year professional doctorate program which has been the minimum requirement for practice in the UK for over 16 years. There is no 'apprenticeship' model in the UK, and this is in fact the case across Europe.

As Clinic Director and lecturer on the University of SA Clinical Psychology Master's program I am involved in training Clinical Psychologists during their two year postgraduate training. This training program is extremely rigorous. It ensures the highest levels of expertise and competence both in theory and best practice. Entry into the training requires a high level Honours degree. In addition we require a stringent interview process before entry into the program.

It is of great concern to me that the fourth year graduate and other specializations in psychology lack appropriate training and skill in assessing and treating mental illness as specified in the better access scheme. In fact many of the candidates on our program are fourth year graduates who have previously practiced as Generalist Psychologists – and it is clear that the Master's degree requires a significant advancement in their training. Although they have had previous supervision and placements, I can honestly say that they have been no more competent or further advanced when they begin their training with us than those who are starting from scratch with no previous experience. Often they come in to the program feeling confident about the experience they have previously gained, but then describe feeling overwhelmed and surprised by the fact that they have so much more to learn and do not find themselves at any advantage in this regard over their newly started peers. On this basis, I personally would not consider recommending anyone I know to see a 'psychologist' who has no postgraduate training , but who has simply carried out a post-Honours apprenticeship – this would be the equivalent of referring a patient with an infection or indeed cancer to a staff nurse. In view of the discrepancy between a clinical psychologist and a psychologist who lacks comprehensive training in providing specialized interventions under the Better Access initiative, it is astounding and concerning that the two-tier system of payment for clinical psychologists is being questioned.

2) Reduction of sessions available to patients under the Better Access initiative:
I also wish to register my very deep concern regarding the Better Access initiatives that would reduce, rather than increase, the number of consultations available to patients; and the assumption that clinical psychologists only treat patients with low to moderate mental health illnesses.

One of the main goals of our University Clinical training course is to provide training to Master's level Clinical Psychologists with skills to treat both straightforward and more complex disorders. This involves teaching in highly sophisticated treatment modalities and advanced forms of Cognitive Behavioural Therapy. The overwhelming majority of my own patients have chronic moderate to severe mental illness (psychological disorder). This includes patients who have personality disorders (especially Borderline Personality Disorder), complex trauma, medically unexplained illnesses and eating disorders. There are very limited services for clients who have problems with this level of severity and chronicity. Due to the complexity of these presentations, services have to be provided by a clinical psychologist who has advanced knowledge of assessment, diagnosis, case formulation and treatment modalities.

Most of the patients I have seen have never had previous access to psychological treatments that work. Many have had non-specific counselling, been prescribed psychotropic drugs, or admitted to psychiatric hospitals. At best these treatments represent a short-term band-aid approach to contain immediate problems.

The vast majority of my patients are bulk billed to ensure equality of access to psychological treatment. I also see the families (e.g. partners and families of patients with eating disorders) for

free. In this way I am working within the ethos of making services accessible to those who would otherwise find such access unavailable. When my patients' medicare sessions run out, I continue to see them weekly for free. I would not consider it ethical to stop seeing a client with Anorexia Nervosa after 10 (or even 18) sessions because they were no longer funded under the Better Access scheme. This includes treatment planning and provision of treatment resources to patients, liaison with medical practitioners and others, correspondence, referral of patients to facilities such as inpatient detox services, Court and Centrelink reports, sending requests for medical records, email treatment support, calls from patients out of hours, hospital visits and travelling expenses which can be considerable. None of this is subject to any form of reimbursement or remuneration.
These are the patients who require more intensive and longer term treatments (e.g. the minimum number of CBT sessions recommended for straightforward Bulimia Nervosa with no co-morbidity is 19 sessions (e.g. Agras et al., 2000) and who are mostly too disabled by their condition to earn enough to pay for therapy. They are also often too disabled by their difficulties to stand up for themselves and to express what they need (especially at a political level).

There is no evidence to support the argument that: *The new arrangements will ensure that the Better Access initiative is more efficient and better targeted by limiting the number of services that patients with <u>mild or moderate mental illness</u>* (emphasis mine) *can receive, while patients with <u>advanced mental illness</u> are provided more appropriate treatment through programs such as the Government's Access to Allied Psychological Services (ATAPS) program'*.**

Many of my patients with moderate to severe mental illness **are in fact referred to me** by the Divisions of General Practice and State mental health services because they do not have the resources or clinical expertise available, or funded, to provide specialized psychological treatment services. In addition, if patients were to access such services they would in all likelihood be exposed to practitioners who do not have dedicated post-graduate training in mental health and/or any significant psychological training. In addition, they would have considerable travelling expenses, which most simply cannot accommodate in their budgets.

The government's budget proposal to wind back access to specialized Clinical Psychology services appears to be based on a false premise that patients seen in private practice have mental health problems which are **'mild to moderate'** in severity and are not those most in need.

As a practicing Clinical Psychologist I would like to indicate as highlighted above that the patients seen in the Better Access Scheme by specialists, have complex and serious mental health issues, covering problems such as co-morbid personality disorders and addiction, self harm and suicide issues, trauma syndromes, depression which is very incapacitating, severe anxiety which greatly effects work performance and ability to function, or children who live in dysfunctional families and/or have severe problems within the school system. All this has massive cost and productivity implications. These are the **TYPICAL** type of patients seen by private Clinical Psychologists. The ATAPS program was not designed to replace or to compete with the Better Access initiative.

The number of session required for treatment and recovery from mental illness should be guided by research. The number of Medicare funded sessions available prior to the budget are themselves grossly inadequate:

* An Australian study found that 'The current (Government) policy appears to be suitable for only about one-third of clients who carry the burden of psychological illness' (Harnett et al, 2010). The findings of the study, which are roughly consistent with those found elsewhere, suggest that a minimum benefit should be closer to 20 sessions.

* Another study conducted by the National Institute of Mental Health found that 16 weeks of specific forms of treatment is insufficient for most patients to achieve full recovery and lasting remission.

* In the Federal Government Better Access review there were no recommendations saying that the number of sessions to Clinical Psychologists should be cut.

* The Australian Psychological Society Better Access Review suggested that around half of people would require more than 10 sessions of therapy.

3) **Lack of access to Clinical Psychology services in remote and rural Australia**

The University of SA Clinical Psychology training course currently provides a tele-web psychology service (via IP based videoconferencing) for clients who require clinical psychology services in remote and rural areas surrounding Pt. Augusta. We are training the next generation of clinical psychologists with the knowledge and skills required to begin to address the inequities of psychology services in rural and remote areas.

We hope to expand this service in the future to reach other remote areas. There is a high demand for this service. As you will be aware, it is not economically viable for clinical psychologists to physically travel to remote areas to see one or two patients. Although some clinical psychologists live and work in rural areas, there are difficulties maintaining anonymity, and for obvious reasons many patients prefer to see a therapist who they don't know socially. In addition, ongoing professional development, peer supervision and training are more easily accessed by clinical psychologists if they live in major cities and hubs. There is a growing evidence base which is demonstrating clearly that video therapy is often preferred by patients due to higher perceived confidentiality and anonymity, increased convenience and the opportunity to access specialist therapies that are not available locally (e.g. for an eating disorder). This evidence base is also clearly indicative of the fact that video therapy is equivalent to in-person therapy in terms of efficacy (for a review on this area please see Richardson et al, 2009).

Recommendations

a) Add more Medicare items for specialist clinical psychologists to provide for shorter and longer consultations.

b) Increase the number of sessions available for clinical psychologists to at least 20 to reflect current research and findings from clinical practice (see below).

c) Add a Medicare item to provide for other family members to be seen in joint or separate sessions.

d) Develop innovation in service delivery by funding specialist clinical psychologists to build new service delivery paradigms within small rural and remote medical clinics or medical/community health centres.

e) Provide rebates to clinical psychologists to encourage, retain, and attract delivery of comprehensive services in rural locations, in particular through the use of videoconferencing and other forms of telehealth.

f) There must be flexibility in delivery of services so that those particular patients who require further treatment sessions or follow-up assistance can get help. I would like to highlight the following points:

* Even with successful psychological intervention, people with mental illness can experience a fluctuating course of illness that interacts both with the environment and with the individual's efforts.

* A premature cut-off of the patient's treatment can severely compromise therapeutic outcomes and undermine long-term personal recovery.

* It is important for patients be able to access treatment with someone they know and trust. It is very common to hear from mental illness sufferers that they have been shunted from pillar to post with their subjective life experiences that impact on their mental health either not understood or explored. Mental health recovery is an intensely personal process and it can be held back by the inflexibility of unduly limiting Medicare funded treatment to those in need.

* The patient with a history of mental illness may need to attend briefly in order to learn how to solve or bypass new problems that are unrelated to their illness but could exacerbate their condition. We need to focus on assisting individuals to manage their own conditions while pursuing a meaningful life and not have individuals resort to medication or self-harm in a crisis because of inflexible service provision. In my experience if specialist Clinical Psychology consultations were to lapse the patient can end up being hospitalized for days, all booked on Medicare.

Susan Simpson,
Clinical Psychologist
Psychology Clinic Director, University of SA, Adelaide

2 August 2011

** Gcvv Sections taken from the Federal Budget 2001 (sic) under the heading 'National Mental Health Reform – Better Access Initiative – rationalisation of allied health treatment sessions.

Agras, W., Walsh, T. A., Fairburn, C., Wilson, G.T., Kraemer, H. (2000). Multicenter Comparison of Cognitive-Behavioral Therapy and Interpersonal Psychotherapy for Bulimia Nervosa. *Arch Gen Psychiatry;57:459-466.*

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

Richardson, L. Frueh, C., Grubaugh, A., Johnson, R., Egede, L., Elhai,J. (2009). Current Directions in Videoconferencing Tele-Mental Health Research. Clin Psychol Sci Prac, 16: 323–338.

Cc Minister for Mental Health, Mark Butler ministerbutler@health.gov.au

Cc Shadow Minister for Mental Health: senator.fierravanti-wells@aph.gov.au

Cc Greens Spokesperson for Mental Health: senator.wright@aph.gov.au