

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

Senate Inquiry Regarding the Government's funding and administration of mental health services in Australia

Dear Senators and Members of the Senate Inquiry Committee,

We are clinical psychologists working in the State funded Child and Adolescent Mental Health Services in Western Australia. We make this submission with the knowledge of the Department of Health. Officers of the Department have not sought to influence the direction and content of the submission, which represents our own views.

In the Health Dept WA positions for psychologists working in Child and Adolescent Mental Health Services (CAMHS) are Clinical Psychology positions, requiring post-graduate qualification and endorsement by the Psychologists Board of Australia in this area. There are 173 clinical psychologists FTE working in CAMHS in WA. There are also two neuropsychologists, and three research psychologists with PHD qualifications, or significant progress towards a PhD.

Country Health Services employ some four year trained psychologists and one counselling psychologist in Mental Health Clinician positions. A qualification in mental health nursing, social work, occupational therapy, or a four year degree in psychology are the essential requirement for these positions. There are currently four psychologists working in these positions. Country Health Services also have two clinical psychology positions providing services for CAMHS.

Many clinical psychologists working in state funded CAMHS in WA also work in the private sector, with the permission of their employer. The Health Dept of WA requires employees request permission for this on an annual basis, and specify how any conflict of interest will be avoided. When working in the private sector these clinical psychologists receive referrals from GP's using the Better Access Scheme, referrals for patients accessing services through their private health insurance ancillary benefits schemes, as well as referrals for patients who are fully self-funded.

Comments below in reference to the inquiry terms of reference thus reflect this workforce familiarity with both public and private sector delivery of psychology and clinical psychology services.

Comments regarding:

- (a) the Government's 2011-12 Budget changes relating to mental health;*
- (b) changes to the Better Access Initiative, including:*
 - (ii) the rationalisation of allied health treatment sessions,*
 - (iii) the impact of changes to the Medicare rebates and the two-tiered rebate structure*
 - (iv) the impact of changes to the number of allied mental health treatment services for patients with mild or moderate mental illness under the Medicare Benefits Schedule;*
- (d) Services available for people with severe mental illness and the coordination of those services and (c) the impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program;*

State Mental Health Services and Better Access

The WA Health Department Child & Adolescent Mental Health Services provide services to the 4% of the child and adolescent population meeting the criteria for severe mental health disorders or where there is a severe medical problem with co-morbid mental health issues. The nature of this work requires extensive multidisciplinary and inter-agency collaboration. Resources are needed for the family, and to advise schools on appropriate management or intervention in that environment with specific patients. Frequently these children have parents who experience their own mental health difficulties and are seen by adult mental health services. Intervention is resource and time intensive. Children and particularly adolescents, may move in and out of hospital settings for brief periods while their difficulties are being addressed, predominantly but not exclusively in the early stages. Referrals need to be made through a current treating Health Care Professional, such as a GP or school psychologist, or other government or non-government agencies involved with the family.

We receive a large number of referrals for our services, which are often characterised by long waiting periods, and view the Medicare Better Access scheme as an essential resource for redirection of these referrals. The "Better Access" program provides better access to specialized mental health services which most West Australians would otherwise experience difficulties accessing. In our experience, referrals to private practitioners by GP's are dealt with in a timely and direct fashion, patients do not have to wait for referral meetings to have their referral discussed and allocated as they do in State Govt services, and a first appointment is generally allocated by a private practitioner on contact.

Our experience has been since the introduction of Better Access there has been a noticeable decrease in wait lists and waiting times for many CAMHS community based teams, suggesting that some moderate to severe problems, when dealt with at first crisis point and in a timely fashion, reduce the necessity for intervention further down the track. This has allowed State Mental Health Services to see our clients more responsively. It has also meant that State services can see the more severe and chronic end of the mental health spectrum rather than also having to service young people with less severe mental health problems. We do though acknowledge that some children, adolescents and young people with quite severe difficulties are seen under the Better Access Scheme.

The CAMHS inpatient adolescent unit rely heavily on clinical psychology private practitioners in country areas to provide follow up under Better Access after hospitalization when no public service clinical psychology services are available, and also uses them to cover for the waiting list periods for access to CAMHS services in the metropolitan area following discharge.

The Commonwealth Better Access program and State Child and Adolescent Mental Health Services have thus enjoyed a useful and complimentary relationship to the benefit of patients since the instigation of the Better Access Scheme. Where children and adolescents seen under the Better Access program require brief hospitalisation for mental health difficulties, inevitable in some situations, mental health services in these settings work to assist the continued treating relationship with the private practitioner in a continuum of care, an approach which has been longstanding in relation to private practitioners, and predates Medicare Better Access.

It is important to be aware there is a shortage of Child and Adolescent Psychiatrists in WA, and a particular shortage of Child and Adolescent psychiatrists in private practice.

It is also notable that in two geographical areas where there are few private practitioners using the Better Access Scheme, these problems of long waiting times remain. Services manage these needs in different ways. For one of these services, the waiting period is 12 months. The other service does not operate a waitlist and has indicated there are many inappropriate but high need referrals. The bulk of CAMHS clients that receive a service for longer than 3 months in this second service have chronic complex trauma presentations and presented in acute crisis. Much of the work is in communities and consists of consulting with relevant stakeholders about complex trauma, abuse and behaviour management. Psychotherapy is possible with only a minority of patients and their families. It is a concern that many community members with identified need for therapeutic intervention are not receiving an appropriate service.

Access to private practitioners would be of considerable assistance in these two geographical areas, one of which is metropolitan, and one country. At the moment there is no mechanism for bringing to the attention of the private practitioner community geographical locations where there is an urgent need for Better Access and their services would be of great assistance, and the development of some communication channels regarding this is likely to be of assistance to new private practitioners in planning their practice locations and targeting.

An additional strength of the Better Access program has been the potential for a consumer to choose options for psychotherapists from a far greater selection of practitioners than is available in Non-Govt agencies or Govt services, where the practitioner is determined for them. If consumers are not receiving the service they think they should under Better Access, they switch to a different practitioner. This is particularly important with children and adolescents, where engagement is very important. Working with moderate or severe problems with this age group requires a skilled practitioner. Better Access has enabled consumers to seek these out and engage in maximum decision-making in regard to their psychotherapy in a way that traditional service delivery has not.

Comments Specific to Adolescents and Young People.

Adolescents and young adulthood is the time in life when we see some of the most significant mental health problems first appearing. If untreated, these mental health problems can worsen and have significant impact on the young person's development and capacity to engage in adult roles and responsibilities. We know that length of untreated illness is significantly related to the impact on the severity of the illness, the young person's general functioning and their response to treatment. It is important that services are available and accessible when the young person requires treatment.

Young people can be difficult to engage in therapy. Their motivation to change fluctuates, and services need to be able to engage quickly with them. Having the capacity to respond quickly to referrals is very important with this age group.

For young people in particular, co morbidity is the rule rather than the exception. In addition, substance use is a common co morbid issue for young people. The young people requiring treatment have multiple mental health problems as well as substance abuse difficulties. Mental Health Services are noting that the severity and complexity of mental health problems seen have increased in recent years, with more trauma, co morbid substance use, self-harm, and severe mental health disorders. Specialised state youth services in WA have also noted an increase in young people with psychotic symptoms and drug use at earlier ages in recent years.

We understand and appreciate the contribution of Headspace, and other non government organisations to the continuum of care for young people, however these organisations do not have staff skills or clinical models that can provide treatment for anyone other than youth with mild mental health issues. These types of organisations require an appropriately funded private practice sector and a comprehensive public sector to support them and to provide services for the moderate to severe patient groups. We are aware of the situation presently

where young people are caught in the gap between "case-finding" at Headspace type services and service delivery in CAMHS, which have waitlists. A well developed and financially accessible private clinical psychology sector is an important part of the solution needed to ensure that CAMHS services have the capacity to focus on the most severe cases.

The impact of changes to the number of allied mental health treatment services for Mild/Moderate or Severe Difficulties in Children, Adolescents and Young People

The evidence for treating youth mental health problems indicates that for uncomplicated anxiety/depression in the order of 10-12 sessions are required for moderate mental health difficulties and 20 sessions for more severe presentations.

CAMHS in WA has specialist teams working with children and young adolescents with conduct disorder. These teams have indicated that from the perspective of working with families where children have significant /severe behavioural problems, the initial engagement and alignment process is often drawn out over a number of sessions for a variety of reasons, even though working with the family in their home environment. They suggest that clinicians working with these persons privately in an earlier engagement process would be an excellent investment to reduce severity; however the reduced number of available sessions to 10 will make progress very difficult to achieve. These are mostly highly vulnerable and poor families unable to pay privately for extra sessions or even any gap payments to see a psychologist or clinical psychologist. Ultimate cost savings to the community for even reducing the severity of symptoms with this young population are well known, indicating extra sessions are a good investment.

In general, with regard to children and adolescents we would to raise concern about the unintended negative consequences of the recent changes to the Better Access funding arrangements for effective treatment for child and adolescent patients with mental health disorders. We know that patients who are provided with evidence based treatments have a significantly improved outcome, including reduced risk of relapse in adulthood or development of chronic mental health disorders. This is particularly so for those who are able to access these treatments early in the course of their illness. Children are not independent in their decision-making and require the support and guidance of significant adults to make changes to their mental health. All evidence-based interventions for children and adolescents recognise this. In addition, population based studies indicate some of the vulnerability factors that contribute to the mental health difficulties of children and adolescents are directly influenced by their environment, such as separation and divorce, and mental health difficulties of a parent experiencing depression. Child and adolescent presentations are complicated by requiring more than sessions with the identified patient to treat the problem. Treatment of children and youth typically involves the family, possibly two family constellations, and sometimes schools. This sometimes acts as a disincentive to practitioners to see child and adolescent patients.

The suggested reduction to 10 sessions may result in fewer child and adolescents patients obtaining appropriate treatment, and will certainly contribute to the current disincentive. We are concerned this will mean longer duration of illness, and increased personal, family and community burden as the mental health disorders disrupt the trajectory of young people into adulthood. We strongly recommend that access sessions (including the exceptional circumstances provision) be urgently reinstated for children and youth with mental health disorders. While we have not seen any evidence regarding children and adolescents in the Better Access review, and believe this age group may not have been examined specifically for access to exceptional circumstances provision, we believe the vulnerability of children and adolescents to changes in their environment has relevance to the availability of this provision.

We note the Commonwealth Govt intention to introduce flexible care packages which would include children and adolescents.

We note this consists of ATAPS Tier 1 (mild to moderate difficulties 9-12% population) funding, core funding provided to GP Divisions/ Medicare locals, intended to complement Medicare subsidised service provision and provide mental health services too hard to reach groups. We note this is intended to supplement service through tier 1, by providing services to parents where children are “at risk” of developing a mental disorder or where parents have a current with mental health disorder.

We understand there is also a proposal for new ATAPS Tier 2 funding to supplement current Tier 1 funding and provide an additional, flexible pool of funding for specified groups. We note this includes children, particularly children with conduct disorder. We understand the priorities for this pool are targeted to address service gaps.

We note to provide this infrastructure it is planned funding will be provided to GP Divisions to develop linkages with schools and have appropriate referral pathways.

We respectfully submit that the plan to direct money for this solely through GP Divisions as previous ATAPS programs is quite achievable for Tier one services. School psychologists are already engaged in a degree of intervention with mild mental health difficulties in school settings in WA, although this intervention generally concentrates on conduct difficulties.

We anticipate there would be considerable workforce attraction difficulties engaging clinical psychologists to work with Tier 2 (moderate) and Tier 3 (severe) difficulties using ATAPS funding. These are outlined in the section on workforce implications.

Our recommendation is to continue to use Better Access primarily for children and adolescents for moderate and severe difficulties, with an increased flexibility around service delivery, and engage ATAPS for Tier one (mild) to moderate difficulties, with money for this to go directly to GP Divisions/Medicare Locals, and would specifically include the provision of parenting groups for children with mild difficulties for a range of disorders.

c) The impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program (further comment)
and

(e) Mental health workforce issues, including:

- (i) the two-tiered Medicare rebate system for psychologists,*
- (ii) workforce qualifications and training of psychologists, and*
- (iii) workforce shortages;*

Traditionally in Western Australia, psychologist registration included a number of specialist titles (e.g. Clinical Psychologist, Clinical Neuropsychologist, and Developmental Psychologist). These titles reflect the qualifications, the level of training and the area of work undertaken by the practitioner. The establishment of these areas of specialisation arose in the mid 1960's from a demonstrated need for additional qualification and training (at that time in the area of Clinical Psychology) which substantially exceeded that which was capable of being provided by the four year Bachelor of Psychology Degree. The first two clinical programs in Australia were established in Western Australia, at UWA, and in Sydney, respectively. The acceptance of this need in WA was demonstrated by Government Departments, including the then Mental Health Services, offering remunerated cadetships to enable four year trained psychologists to complete, on a full time study basis, this additional training. This cadetship system ceased in the early 1980's when due to the by then two locally available clinical programs and recruitment drives in the UK and South Africa, the Health Dept Clinical Psychology workforce constituted clinical psychologists and neuropsychologists, with a minimum of six years training the expectation for working in mental health, making cadetships no longer necessary.

In a recent Industrial Relations case in WA (resolved in 2002) it was demonstrated and accepted that clinical psychology specialisation was both cost saving and resulted in improved patient care to the Health Dept of WA, with a separate paid progression system established for clinical psychologists to that for other specified professional callings. This is not available to four year

trained psychologists or psychologists trained in non-mental health specific specialties, such as counselling psychologists.

Within the private sector, prior to the introduction of Better Access, clinical psychologists in WA arrived at arrangements re rebates with the main Health Insurers. Rebates for the two main insurers providing 90% local coverage also required qualifications in clinical psychology.

The situation in WA regarding mental health provision has for sometime been proceeding down a path more akin to other western countries such as the UK, USA, Canada and South Africa, where 6 year of training is required to work as a psychologist in mental health, than Eastern Australia. NZ sits between requirements in WA and requirements in the rest of Australia, at five years.

In regard to workplace shortages, CAMHS in WA is not experiencing difficulties in recruiting to base grade clinical psychology positions currently, other than in Rural and more particularly Remote areas.

In two of these areas there are available private clinical psychologists.

There are four clinical psychology post-graduate programs in WA, and provided intake can keep pace with population growth, there do not seem to be foreseeable difficulties.

Practitioners with a four year degree can, and are in WA, employed in mental health practitioner roles, with the Health Dept, and with Non-Govt agencies. A similar system operates in the UK where there are identified levels of intervention from those requiring a general skill level to those requiring a specific skill level, the later undertaken by six year trained psychologists. This parallel model is similar to the Better Access model, where tier one four year trained psychologists (known as psychology technicians in the UK) and other practitioners provide focussed intervention strategies and clinical psychologists provide a range of psychotherapies.

In evaluating the two tier system it is important to bear in mind that the number of sessions is only part of the story, the other part of the story is what is provided in the sessions. Reliable information about this is not available, however by definition this is different for the two tiers who are contracted on a fee for service basis to provide different components of the Better Access program. It would be expected on the basis of current literature in the area, psychotherapies provided by clinical psychologists would take longer than the focussed strategies for specific problems such as relaxation techniques or problem solving strategies provided by four year trained allied health practitioners.

There will undoubtedly be patients who were referred for focussed strategies when they should have been referred directly to a clinical psychologist, and patients referred to clinical psychologists who could have been referred for focussed strategies.

The only reflection of this in the Better Access evaluation review seemed to be the large number of patients seen under the ATAPS program later referred to Better Access to see a clinical psychologist.

The Better Access system would benefit from clearer guidelines on when to refer for which program, from the addition of an outcome measurement system at six session reviews, and consideration of a further six sessions dependent on this. If a problem does not lend itself to 6 sessions of focussed strategies due to complexities, this would be an indication that the patient should be referred for psychotherapies. There would be a limit of six sessions for focussed intervention strategies. In this context it is important that the current list of focussed therapies be reviewed: it is questionable whether some, such as interpersonal therapy, could be delivered in six sessions, or in focussed format. All protocols for this therapy require more sessions than six. Consideration should be given to moving the focused strategies component of Better Access into the ATAPS program, where it may be possible to provide more safeguards on what is provided, and in the case of children and adolescents, provide a broader range of strategies for mild difficulties.

For this system to work Clinical psychologists would also carry responsibility to conduct a comprehensive assessment at first interview, with the use of compulsory consumer completed measurement instruments. These must show at least moderate disorder for psychotherapies to be undertaken. If not, the clinical psychologist would be expected to refer for focussed strategies.

The system would be subject to audit. 12 sessions of psychotherapy may then remain fiscally robust under the Better Access scheme.

Using this differentiation it would be expected that focussed intervention provided by general mental health practitioners would be provided for a shorter period time with mild to moderate difficulties for more people. This would constitute the bulk of referrals. This is consistent with the Better Access evaluation, where 72.7% of consumers received 1-6 sessions.

In the child and adolescent area ATAPS tier one funding directed towards children with mild difficulties could also be used to undertake parenting interventions in group format, such as the triple P program, which on the basis of best available evidence, would be expected to result in fewer children and adolescents needing to be referred for psychotherapies.

Many of the interventions which could be undertaken at this tier are manual-based.

In a stepped care model, where six sessions of focussed strategies under ATAPS service provision is insufficient, patients would be referred on to Better Access.

Clinical psychologists would remain with Better Access (and would see fewer people than those seen under the ATAPS program) focusing on those with moderate or severe difficulties, for longer periods of time.

This would provide a more appropriate utilisation of the skill set of the two groups, and provide some safeguard for the public that they were being referred to an appropriately qualified practitioner for the service they were receiving. There would be the possibility for the GP Divisions to build in greater supports for four year trained psychologists. There are indications from the Better Access review would be helpful – one of the predictors of outcome for psychologists, though not clinical psychologists, in the review was patient dropout, suggesting a need for more support or advice in delivering the focussed strategies.

The fee for service model would be retained for Better Access, where it is important consumers form direct relationships with the practitioner and have the freedom to move on if needed. The Better Access evaluation indicated a substantial number of sessions provided under this program are bulk-billed or charged only the rebate fee.

It would provide a way in which ATAPS and Better Access programs could work together more constructively for children and adolescents.

It would also solve the foreseeable difficulties of attempting to persuade clinical psychologists to work for the ATAPS program. Funding to provide services to the moderate or severe end for children experiencing mental health difficulties would be best targeted to professionals most equipped to deal with this area. It seems likely that those managing ATAPS programs in GP Divisions will be motivated to provide as many services as possible, with as low a fee as possible flowing to the psychologist. As no gap payment fee is allowable, this will result in clinical psychologists being paid less to see patients with more severe difficulties than they are able to charge for less severe difficulties under Better Access. Clinical psychologists will not be motivated to treat the more ill patients. This has particular implications for children and adolescents, where at the more moderate to severe end of the spectrum, the practitioner needs to have quite a degree of skill to adequately engage and treat. This would seem to be an approach not in the best interests of patients.

So, in summary, it is suggested tier one and focussed interventions be administered under ATAPS, and psychotherapies, targeted towards the moderate to severe end of the spectrum, which should be required for far fewer patients, be administered under Better Access, which will give patients maximum choice and attracts practitioners more skilled to deal with the difficulties.

- (f) The adequacy of mental health funding and services for disadvantaged groups, including:*
- (i) culturally and linguistically diverse communities,*
 - (ii) Indigenous communities, and*
 - (iii) People with disabilities;*

We would like to make some comments regarding Children with Acquired Brain Injury (ABI). Some children with ABI have compensation money and access private clinical psychology services as needed and when appropriate, claiming directly from insurers. It is considered possible changes to the number of sessions available under Better Access will drive up cost of private service in the longer term, this could have negative impact as Insurers may limit number of sessions they are prepared to pay for.

There are some children in rural and remote communities with ABI who rely solely on private clinical psychology services through Better Access. Not all have compensation funding and not all can access CAMHS.

The adults with ABI who were previously seen in the children's hospital in Perth constitute a neglected group. Currently these adults do not have access to any of the Rehabilitation services provided by the WA Health Dept. These patients are discharged to their GP for monitoring and ongoing management. Although many will do very well, it is predicted that quite a few will require psychology input sometime in their adult years and they are more likely to be referred to private practitioners for services. This is a group who will be quite vulnerable to any funding changes.

- (g) The delivery of a national mental health commission;*

A Commission would be of particular value in identifying current or foreseeable gaps and communicating these in a way that allows for better planning on the part of private practitioners.

As indicated earlier, private practitioners at the moment have no way of knowing where they might usefully set up private practices other than word of mouth. It would be useful to have informed information regarding population mapping and current distribution of private practitioner services. This would certainly help practitioners at ground level in targeting for Better Access and assist with the unevenness of coverage and impact on State Mental health Services described previously.

- (h) the impact of online services for people with a mental illness, with particular regard to those living in rural and remote locations and other hard to reach groups; and*

Online services are a useful way of conducting intervention. We would caution against a "one size fits all" approach to the area.

For children and adolescents, where intervention requires the involvement of parents as well as the identified patient, videoconferencing is a common way to conduct intervention services at a State level in WA and mental health services have become accustomed to this medium, which is not one currently covered by Better Access. Negotiating access for private practitioners to state run video conferencing facilities which are quite available now in many parts of WA, and allowing this form of delivery under Better Access, may be worth investigating as a further option for intervention delivery.

- (i) Any other related matter*

The introduction of a more flexible approach to the caveats around Better Access sessions for children and adolescents is strongly recommended. At the moment all intervention must take place with the child or adolescent present at the session. This is clearly inappropriate on occasions, where conversations need to take place with the parent directly. It can be difficult for parents and unproductive to speak openly in front of their children regarding issues, such as parenting arrangements when parents are separated, which may be impacting on management of the child's mental health difficulties. It can be similarly unproductive and at times harmful to have children witness the degree of tension when discussions about the child's mental health need to take place with both parents under these circumstances.

We recommend the requirement that the child be present for all sessions be changed, and there be the introduction of flexibility in this regard, or at the very least the introduction of the possibility two sessions out of every six can be conducted without the child present.

Thank-you for the opportunity to comment.

Clinical Psychologists

Child and Adolescent Mental Health Services

Western Australia

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