

**Submission to the Community Affairs References Committee:**

**by the undersigned endorsed clinical psychologists practicing in the Northern Territory**

**4<sup>th</sup> August 2010.**

**SUMMARY**

It is contested that the proposed restrictions to the 'better access' funding for psychological services will disadvantage consumers presenting with moderate to severe 'non-psychotic' mental disorders. The level of disability suffered by this clinical population will likely have significant negative impacts upon important life domains, including productivity.

The impact of the proposed changes will most likely be worst felt in rural and remote regions, where there are often limited options for treatment available in the government or not-for-profit sectors.

The potential loss of recognition for an 'endorsed' area of psychological practice ('Clinical Psychology') is considered a backward-step and contrary to national and international trends. It is asserted that such changes would be undermining appropriate recognition of the needs of consumers within the moderate-severe range of disability enshrined in the very structure of the 'better access' scheme, the 'two-tier' structure.

The last section of the submission suggests ways to achieve more targeted expenditure through the better access scheme but not resulting in disadvantaging people with legitimate needs or those members who may fall within clinical population regarded as high priority.

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The undersigned provide the following document for consideration by the Community Affairs References Committee inquiry regarding the Federal Government's 2011-12 budget changes relating to mental health services in Australia.

The content of the submission provides information considered relevant for the following terms of reference and areas of interest of the committee:

1. Changes to the 'better access' scheme, including:
  - (i) the rationalisation of allied health treatment sessions,
  - (ii) the impact of changes to the Medicare rebates and the two-tiered rebate structure for clinical assessment and preparation of a care plan by GPs, and
  - (iii) 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;
2. The impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program;
  - (i) services available for people with severe mental illness and the coordination of those services;
3. 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;
4. The adequacy of mental health funding and services for disadvantaged groups
  - (i) people living in rural and remote locations
  - (ii) people with co-morbid conditions and disabilities

## **Areas of change supported or considered reasonable.**

We fully endorse and support the recent Federal budget announcements regarding improved early intervention services for young adults (eg. early episode psychotic conditions) and also the improved funding for rehabilitation and support for people suffering from mental disorders often associated with chronic residual symptoms and associated disability. This will hopefully assist individuals and their family's better cope with the often life-long residual disabilities associated with some mental disorders (eg. psychotic spectrum conditions such as the range of disorders within the diagnostic category of Schizophrenia).

The need to 'manage' the costs associated with the demand for services through the 'better access' scheme is also understood. It is acknowledged that for consumers presenting with relatively mild clinical disability, the proposed reductions in the total number of sessions may have relatively little impact upon the quality of outcomes achieved.

## **Aims of the Submission**

The submission below represents the considered opinions of the undersigned in response to the perceived risks posed by some of the changes to the 'better access' scheme contained within the 2011-12 budget. We consider that there are very significant negative consequences associated with the proposed changes, which were perhaps unforeseen or underestimated.

The submission follows consideration of all the evidence and argument available and specifically aims to achieve the following objectives;

1. Make representations on behalf of those consumers who are likely to face 'disadvantaged' rather than 'better' access to appropriate psychological treatment.
2. Assert the need for special consideration regarding consumers living in rural and remote regions.
3. Re-affirm that specialised psychological treatments are often required to effectively assist consumers with moderate-severe disability associated with 'high prevalence' mental disorders (ie. non-psychotic spectrum conditions). Appropriately providing for the needs of this clinical population was overtly present in the structure of the 'better

access' scheme (ie 'two tiered structure'), the document merely asserts that these foundations should be respected and retained.

4. To suggest retention of pathways of referral for those clients with established moderate-severe disability to continue receiving the intensity of psychological treatment most likely to bring about sustained recovery.

## **Risk of 'disadvantaged access' for people suffering moderate-severe disability.**

It is considered that some of the proposed restrictions to the 'better access' scheme as part of the 2011-12 budget would appear to be in danger of resulting in negative consequences for people suffering from moderate to severe disability associated with high prevalence conditions, such as Depression and Anxiety disorders (rather than 'psychotic-spectrum' disorders). Also within this more severe disability range, are consumers with more complex needs (eg. dual diagnoses - multiple disabilities) who are considered to be at particular risk of disadvantaged access.

It would appear that the recent analyses underpinning the funding changes have not adequately taken into consideration the variability in severity and complexity of presenting problems demonstrated by a (substantial) minority of clients referred within the 'better access' scheme. It has actually been rather difficult for us to believe the apparent lack of sophistication in recent announcements. These important issues were considered to have been accepted and in fact embedded in the very structure of the scheme - by differentiation between 'focussed psychological strategies' for mild disability and more intense, evidence-based 'therapies' for more severe or complex presentations.

Statistically, it would be predicted that most presentations would be characterised by 'mild' disability and be associated with symptoms consistent with relatively high prevalence conditions (eg depression or anxiety). This description appears to be consistent with the data available. Appropriately facilitated 'focussed psychological strategies' can effectively treat this level of disability, often because the individual is reasonably resilient and/or they have other protective factors (eg. solid support).

Within the range of referrals there would also be expected to be a smaller number of more severely disabled, and/or complex presentations (eg. co-morbidities). These people would have a level of disability that would likely result in rather more significant difficulties across fundamental life domains, such as employment and relationships. Most of the presenting problems would likely be consistent with the features reaching criteria for diagnosis of a mental health disorder (eg Major Depressive Episode).

It is considered that there would be an abundance of evidence now available to the committee regarding the efficacy of psychological treatments provided by the appropriately trained, supervised and experienced psychologists for moderate-severe levels of disability<sup>1</sup>. It should be noted that if we assert that an appropriately trained and experienced Clinical Psychologist would most likely be best equipped to facilitate optimal outcome for adult consumers with moderate-severe mental health-related disabilities. For consumer's presenting with disabilities toward the more 'severe' end of the spectrum, the capacity under previous provisions, to request consideration of 'exceptional circumstances' and be granted an additional 6 sessions (a potential total of 18), often made significant psychological treatment achievable.

It is of great concern that, in our opinion, the changes will inevitably lead to increased suffering for individuals and their families, with associated loss of productivity and potentially adverse effects on any involved children. This outcome is predicted to be partially resulting from psychologists restricting accepted referrals of consumers who likely have moderate-severe disabilities and/or have additional complexities (eg. co-morbid conditions, cultural or linguistic complications).

A major contributing factor for the restrictions described above, is predicted to be because the revised funding arrangements actually presents practitioners with an ethical problem. This is because it is *known* that psychological treatment of a consumer suffering moderate-severe disability would usually require a greater number of sessions than would appear to be available under the proposed changes (i.e. 6+4 sessions per annum). As a total allocation of sessions this would contradict estimated requirements for completion of relevant psychological treatment outlined in commonly accepted 'evidence-based' clinical practice guidelines<sup>2</sup>.

The relevant issues are perhaps best illustrated by an example. Any person can experience an event so awful (eg natural disaster, accident, assault) that it leads to the development of Post-Traumatic Stress Disorder (PTSD). The affected person will likely experience significantly declining ability to function in important areas – potentially putting in jeopardy valued

aspects of life such as work or close relationships. When the event experienced is not covered by relevant insurances (workers compensation, motor vehicle accident etc) then the 'better access' scheme provided an avenue for appropriate treatment.

The Australian Centre Post-Traumatic Mental Health (regarded as the peak body for treatment of psychological trauma) treatment guidelines regarding psychological intervention for PTSD estimates 8-12 sessions of 'trauma-focussed therapy' alone to be required in most cases and a greater number for more complex presentations<sup>2</sup>. It important to understand that this allocation relates solely to the specific trauma-focussed work. There would be additional sessions required to assess and prepare the person and following the trauma focussed phase (for optimal outcomes), sessions assisting the consumer consolidate and refine therapeutic gains to maximise long-term, self-sustained recovery (ie. relapse prevention and health maintenance components). It is considered usual that approximately 20 sessions would be required to effectively treat the intensity of symptoms and disability generally associated with 'moderate' intensity PTSD.

Six plus four sessions is therefore very unlikely to result in an acceptable outcome in PTSD cases. Such referrals are extremely unlikely to be accepted in the future, because of the real risk that empirically -supported approaches as described in ACPMH guidelines (eg. containing exposure therapy), if only partially completed, could potentially worsen the persons condition.

There is concern that accepting such referrals under the proposed restrictions could potentially leave psychologists exposed to litigation. It could be easily demonstrated that the practitioner accepted the referral when the allocation of sessions was significantly less than recommended in accepted clinical practice guidelines<sup>2</sup>. It could be argued that the practitioner should have been able to predict that treatment would not be completed – and therefore had fore-knowledge regarding the potential of *doing harm* to the consumer.

## **Rural and Remote considerations**

It is well recognised that in rural and remote regions there is relatively poor access to psychologists and particularly those with 'endorsed' areas of expertise. Even government mental health services find it difficult to recruit and retain staff. For example, in both Darwin and Alice Springs there have been *no* psychologists available to provide clinical services within the adult mental health services for several weeks. It is considered worth repeating – to our collective knowledge there are currently *no* psychological services available for the most

severely disabled adult consumers within the public sector in the two major population centres of the NT.

In rural and remote regions the significantly lower numbers of endorsed practitioners amplifies the negative effect (outlined above) for those consumers with moderate-severe disability. Unlike larger southern population centres, the not-for-profit sector in the NT is relatively small, and mostly focussed upon providing a range of support and accommodation services to the more severe and chronic clinical population. This is often in 'shared care' arrangements with government mental health services.

When psychologists *are* able to be recruited to public mental health service, the core clinical population of these services are consumers diagnosed with psychotic spectrum disorders. As a result of the limited public-sector availability, there may be literally no access to endorsed clinical psychologists for consumers suffering moderate to severe disability associated with *non-psychotic* spectrum disorders.

In the NT, most psychologists with clinical endorsement work in private practice. The previous 'better access' provisions allowed for the intensity and duration of psychological intervention usually required for consumer demonstrating moderate-severe disability to achieve good outcomes.

The reality (under the above provisions) has been that quite often endorsed clinical psychologists accept the more complex/severe/dual diagnosis referrals from GP's, or public and private psychiatrists. This happens because the referring Doctors know they cannot access the level of clinical expertise from the public sector or 'generalist' psychologists in the community. It has not unusual for consumers to have been diagnosed by the public mental health service with a moderate-severe disability and referred to a GP with recommendations to the GP regarding referral on for specialised external psychological treatment (because such treatments are not possible within the public sector).

It was considered worth noting that the consumers comprising the population described above (experiencing more severe disability ) are often also suffering some degree of financial hardship and therefore do not represent a very lucrative market for private practitioners. In rural and remote areas, often these consumers are in fact 'bulk billed' with the referrals being accepted *because* of the lack of available public sector or not-for-profit service delivery options for clients with more severe or complex problems.

## Recognition of ‘endorsed’ areas of practice

Rule nine in the constitution of the Australian Psychological Society<sup>3</sup> specifies the criteria for *full* membership – describing that to be successful, a candidate needs to demonstrate training and experience equivalent to someone who has completed an APAC accredited *post-graduate* qualification in psychology, extending over a period of not less than two (2) years full-time or an equivalent period part-time. This is six years tertiary education, including research and/or coursework to be considered a *full* member of the APS. Demonstrating equivalence to successful completion of six years of appropriately relevant academic training and also a satisfactory period of supervised practice has been the ‘benchmark’ for membership to any of the APS ‘colleges for many years.

Since the inception of ‘better access’ and in particular the ‘two-tiered’ rebate system, there has been particular attention and effort afforded to clarifying appropriate pathways for other psychologists to gain ‘equivalence’ to clinical psychologist – and therefore improved rebates. It is considered that delegated representatives of Medicare, the APS and the college of clinical psychologists have cooperated effectively over several years, as evidenced by the actions of the Medicare Assessment Team in facilitating appropriate pathways to achieving clinical college equivalence for many psychologists.

It should be noted that within the profession, this has been very difficult period for clinical psychologists. As a collective, we have been the target of what at times is considered unfair criticism –often asserting that we are motivated by exclusivity and self-interest. It is contested that collectively we have most often sought to *promote high standards* in the quality of service provision, particularly for those consumers with most significant mental health disabilities that are responsive to psychological interventions.

More recently recognition of the complexity inherent in the discipline of ‘Psychology’ would appear to have been demonstrated by the range of ‘endorsed’ areas under the recently implemented national registration scheme<sup>4</sup>. It is considered encouraging that the broader health sector is becoming more sophisticated in their appreciation of the areas of specialised practice. It is considered that such changes reflect increasing recognition regarding the influence of ‘psycho-social’ maintaining factors in health outcomes. This is particularly the case in populations identified as high priority, such as Aboriginal health, obesity, and alcohol-related problems.

Unfortunately it is considered that very little has been achieved regarding more ‘systemic’ modalities of intervention. We fully support more appropriate recognition of our colleagues

in other endorsed areas of practice for the specialised interventions they could bring to improving health outcomes across a broad range of health problems.

As a general principal we strongly suggest that consideration be given to how the expertise in the other endorsed areas of psychology may be better integrated into the public health system. However, as appropriate to the nature of our particular body, this submission is primarily focussed upon the 'clinical Psychology' endorsed area of practice.

### **Specific relevance of clinical psychologists for 'better access' consumers demonstrating moderate-severe disability.**

In the 'two-tiered' structure of the 'better access' scheme there appeared to be implicit recognition of a parallel between the 'generalist' and 'specialist' areas of practice that exists in the Medical discipline. Essentially, in the area of general medical ill-health - if the presenting symptoms are considered 'mild' with no requirement for intense or specialised treatment - GP-based intervention are entirely appropriate. However, it is considered appropriate to refer more severe or complex presentations to medical practitioners who are *professionally recognised* as having acquired specialised knowledge and skills. It is considered that this principal was understood to apply in the area of 'mental ill health' and was incorporated into the very structure of the better access scheme – for the spectrum of service intensities to reflect the variance in consumer service requirement.

Other Western nations (eg UK and USA) recognise that the practice of 'clinical psychology' involves the acquisition and judicious application of a specialist body of knowledge<sup>5,6</sup>. In the NT there has been legal precedent set that the expert opinion of an appropriately trained and experienced clinical psychologist in the diagnosis of PTSD, can be considered to be equivalent worth to that of a psychiatrist<sup>7</sup>. There are Australian industrial precedents<sup>8</sup> supporting the assertion that appropriately trained and experienced clinical psychologists will most likely be best equipped to facilitate optimal outcomes for adult consumers with moderate-severe mental health related disabilities<sup>1</sup>.

Removing aspects of the better access scheme that appropriately distinguished the value that clinical psychologists can add to clinical outcomes in consumers with moderate to severe disability is considered a grossly regressive step.

## **Suggested resolution of the issues outlined above**

Finding the best balance between managing the costs associated with the ‘better access’ scheme whilst providing consumers with appropriate services, is the goal everyone wants to achieve. Success would seem to revolve around accurate identification of clinical need and the overall cost-effectiveness of appropriate service delivery (compared to the cost of the untreated disability).

It is accepted that the proposed changes to the funding arrangements in the ‘better access’ scheme may result in more cost-effective, whilst also clinically appropriate interventions, for consumers *demonstrating relatively mild disability* associated with mental health problems.

The previous sections of this submission have focussed upon concerns that consumers with moderate-severe disabilities will be disadvantaged by the proposed changes. It is further asserted that there is substantial evidence available to the committee regarding the economic and social costs associated with untreated, aptly termed ‘high prevalence’ disorders, such as Major Depression.

The concept of ‘moderate to severe disability’ applies to a broad range of diagnosed clinical disorders. To assist the committee members to better understand, some important examples would include people who have experienced recurrent, very difficult episodes of Major Depression (perhaps involving suicidal behaviour). Also people who have relatively recently developed an anxiety disorder such as Panic Disorder, or PTSD, and are suffering particularly acute symptoms which would particularly benefit from ‘early intervention’. Finally it is very important for committee members to understand that most consumers in this clinical cohort present with multiple diagnoses including co-morbid mental health, substance-related and/or physical conditions.

Rather than essentially disenfranchising the most seriously disabled consumers from appropriate treatment, it is considered that the government would much prefer to manage costs by more targeted access to services. The problem appears to be the accurate identification of the moderate-severe clinical population, to enable better targeted access to evidence-based therapy.

## Improved pathways to more intense psychological therapy

The following suggestions use existing infrastructure to provide additional requirements which could create several (parallel) referral pathways that potentially increase the accuracy of identifying consumers demonstrating moderate-severe disability. The circumstances suggested to be appropriate are;

- ‘Shared care’ arrangements with a treating psychiatrists
- GP managed following assessment and medical referral from emergency departments or members of the assessment teams of public mental health services (including state registered ‘authorised Mental Health Practitioners’).
- Where the referral to the GP is from a public mental health service and follows psychiatric assessment and perhaps a period of acute treatment.

These are considered very modest measures, however if these were formalised and appropriately implemented could result in some of the most severely affected consumers being identified (eg. suicidal, acute anxiety presentations) and referred for treatment commensurate to the severity of disability. The above suggestions were also considered to be consistent with the movement toward ‘shared care’ for consumers with moderate-severe disability associated with mental disorders. Creation of associated item numbers would allow for monitoring of the referrals over time.

There may be other processes developed which could also improve the accurate identification of the moderate-severe disability clinical cohort. We strongly encourage the committee to request information relevant to explore ways of better identifying the population of consumers demonstrating moderate-severe disability.

Applied to a better identified population, it is considered important to retain the allocation of 6+6 sessions (+6 in exceptional circumstances) related to psychological therapy. There is considered to be an overwhelming amount of evidence supporting the need for relatively intense and often specialised interventions to facilitate sustained functional outcomes for consumers more severely affected by mental disorders.

Merely by recommending more specific demarcation of the item numbers related to ‘psychological therapy’ (eg. 80010) there would seem to be the potential for the current committee to advocate for consumers in the moderate-severe disability spectrum to continue receiving appropriate treatment. We strongly urge the committee to consider the importance of access to the intensity of psychological intervention appropriate for the needs of these

people, their families, and more broadly the employers and employees perhaps associated with them.

### **Exceptions to the above restrictions**

It is very strongly asserted that there are two circumstances **that should constitute exceptions to any restrictions** in access to the item numbers associated with psychological therapy for consumers demonstrating moderate to severe disability associated with a mental disorder. The two circumstances are;

- Rural or remote location
- Where the service is a specialist intervention in an identified ‘high priority’ area.

Notably these populations refer directly to areas specified as being of particular interest within the terms of reference of the committee.

We all work in geographical locations and service access ‘realities’ that *usually* satisfy both the above circumstances. We greatly appreciate the direct recognition of the disadvantaged access to services often suffered by consumers who fall into the above clinical cohorts. We also gratefully acknowledge the opportunity to advocate on their behalf.

Essentially we wish to indicate in the strongest terms possible, that because of ‘exceptional need,’ arrangements regarding access to psychological therapy from an endorsed clinical psychologist should be excluded from any budgetary restrictions for the above populations.

Furthermore, we completely endorse the inclusion of the above populations as areas of particular interest, and collectively encourage the committee in their efforts to explore new ways that the above consumers can obtain equitable access to appropriate services.

### **Relevant documents, facts and websites**

1. Work Values Document – WA Health Sector 1998
2. <http://www.acpmh.unimelb.edu.au/resources/resources-guidelines.html>
3. <http://www.psychology.org.au/Assets/Files/APS-Constitution-and-Generic-Rules.pdf> - rule 9,
4. 2010 National Registration and Accreditation Scheme specialised Areas of Endorsement - <http://www.psychologyboard.gov.au/>
5. <http://www.clinicalpsychology.org.uk/>
6. <http://www.apa.org/ed/graduate/specialize/clinical.aspx>
7. Quinton, G. (1998) Clinical psychology and medical diagnosis, *Clinical Psychologist*, 2, pp 4-8.
8. Western Australia commenced Specialist Title Registration in 1965

**PARTICIPANTS PAGE**

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**Endorsed clinical psychologists practicing in the Northern Territory**

We, agree with the contents of this submission and tender it with the earnest hope that it may benefit the deliberations of the committee.

Finally, we thank the committee for their consideration of the submission.

<p><b>Signature: David Moorcroft</b>  <b>Name: David Moorcroft</b></p>	<p><b>Signature: <i>Jo-Ann Delahunty</i></b>  <b>Name: Jo-Ann Delahunty</b></p>
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