

In preparing this submission, I am writing from the perspective of a full time clinical psychologist, and part time researcher into mental health service delivery.

I am currently working in private practice in a metropolitan region. I have a PhD and have been registered as a psychologist for over 10 years. I have convened undergraduate and post-graduate psychology programs at two of QLDs universities, and given guest lectures at the other two. I have also supervised around 20 psychologists on their way to either general registration or college membership.

In my private practice, I see mostly clients who would not have been able to afford treatment prior to the introduction of Better Access. I do charge my clients a gap fee of around \$45 per session, however I also bulk bill a significant number, and offer a reduced gap fee of \$6 to a great many more, I have also offered a small number of clients ongoing therapy gratis when their Medicare funded sessions run out, but I have felt it is unethical to terminate therapy at that point. I routinely evaluate my clinical practice, and can therefore state with confidence what my overall effectiveness is as well as my premature drop out rate and other indicators of clinical quality.

(a) the Government's 2011-12 Budget changes relating to mental health;

I note from the budget papers that the government plans to make a large spend on mental health in the coming three years. However, it is important to point out that in the first year of these changes, \$580 million is being cut from existing programs (mostly Better Access), whilst only an additional \$47 million has been allocated.

There is no mention in the budget as to where consumers of the additional \$533 million dollars of services are supposed to seek help in the meantime. Minister Butler has made public statements that he expects people will be able to consult private psychiatrists. However, not only are psychiatry visits more expensive than psychological visits, one of the major reasons that Better Access was established is that psychiatrists are already in short supply, and 6 month wait lists are not uncommon.

In addition, research evidence is fairly clear that changing therapist midway through a course of treatment is a major contributor to therapy failure. A major study demonstrated effect sizes approaching zero ($d = 0.2$) for clients who had to change therapists due to organizational or systems factors. Compare this to clients who were able to remain with one therapist ($d = 0.79$)¹. Such an outcome would mean a massive waste of government money, as well as leading to disillusionment of vulnerable clients.

¹ Miller, S, D., Duncan, B, L., Brown, J., & Sorrell, R. (2006) Using formal client feedback to improve retention and outcome. *Journal of Brief Therapy*, 5 (1), 5 – 22.

Given that the Government's own review of Better Access demonstrated that over 80% of people treated under better access were experiencing "high" or "very high" levels of distress², such a funding cut without realistic alternate arrangements seems like an example of policy on the fly with very little thought for consequences.

(b) changes to the Better Access Initiative, including:

(ii) the rationalisation of allied health treatment sessions,

Whilst cutting the available sessions in Better Access from 12 down to 10 appears like a relatively minor reduction, the more important aspect of this is the removal of the "extra-ordinary circumstances" option of an extra 6 sessions. The government's own review suggests that very few clients actually use sessions 10 – 18, however for those who do these sessions are vital.

My own clinical experience shows less than 1% of my clients have sought "extraordinary circumstances" referrals, yet these clients are often the most vulnerable.

Two cases spring to mind to illustrate this point. The first is an 11 year old girl who I was treating for depression. In session 10 she told me that she finally trusted me enough to tell me a secret. The secret was that a family member was sexually abusing her. I was granted permission by her GP to continue working with this girl for an additional six sessions, which allowed her access to therapy whilst the painful process of notification and child safety began.

The second was a man in his early 30s who I was treating for depression. Between session 9 and 10 experienced the death of his son. He was hospitalized following a serious suicide attempt. We continued therapy for an additional three sessions beyond 12, and he was able to return to a healthy trajectory of improvement.

In each of these cases, I would like the senators to ask the minister to explain the ethics of me referring these clients to a psychiatrist who they have never met before, with whom they may have a lengthy waiting period before they can even see them.

Given the relative infrequency of these "extraordinary circumstances", the additional cost the budget bottom line is minimal, and removal of this provision denies service to those most in need, often at their time of greatest need.

² Pirkis, J., Harris, M., Hall, W., & Ftanou, M. (2011). Evaluation of the Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule (Better Access) Initiative. Centre for Health Policy Programs and Economics

(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;

Whilst several critics of Better Access consistently refer to “mild to moderate” mental illness as the primary target group of this program, the evidence does not support this. The evaluation of Better Access suggests that less than 20% of those seen by this program have “mild to moderate” illnesses.

There is also an implicit assertion that people who have “mild to moderate” illnesses are somehow less deserving of treatment. Former Australian of the year Professor Patrick McGorry has developed an excellent model of service for youth in the early stages of mental illnesses. The government has allocated significant amounts of money to these services. However, one of the central tenants of these early intervention treatment models is that they provide treatment to people BEFORE their illness deteriorates. Headspace provides early intervention to young people, however the same principal applies to adults with mental illnesses, treatment early represents the greatest chance of sustained improvement. Sometimes early treatment involves treating people who have “mild” illnesses.

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

I can only speak from the perspective of my own area, where ATAPS runs largely in parallel with Better Access. The two programs appear to have the same criteria and do the same work. However, my reading of the ATAPS report suggests that ATAPS is an excellent program for non-urban areas where more innovative service delivery models are needed.

My only criticism of ATAPS is that providers are paid for blocks of six sessions after completion. This presents a significant cash flow problem for small businesses if this model were to become a larger proportion of private psychological practice.

I have also had the experience of ATAPS running out of money in their funding cycle, and then refusing to pay for work already undertaken both by myself and by other psychologists I work with. As a small niche program, these kind of administrative problems are inconvenient but not critical. If ATAPS is to become a larger part of the funding mix, then these kind of financial control systems need to be dramatically improved.

(d) services available for people with severe mental illness and the coordination of those services;

Like most clinical psychologists, the majority of the clients I see present with severe mental illnesses. The model of six sessions with review has been excellent for care co-ordination. I am in regular written contact with local GPs, Paediatricians and Psychiatrists, as well as telephone contact as needed.

There is some need for greater informatics sharing between key stakeholders though. I am hopeful that the government is working on improved data sharing between the medical and allied workforce in mental health.

However, for those with severe and persistent mental illnesses (SPMI) the 12 sessions provided under Better Access is currently inadequate. Whilst the current budgetary environment makes this unlikely, in an ideal world the total number of sessions available for these clients would increase rather than decrease. A dose effect relationship is well understood and documented in psychological therapy. A major meta-analysis covering 30 years of research demonstrated that 50% of clients were improved after 8 sessions, 75% of clients were improved after 26 sessions, and 85% of clients were improved after a year of regular therapy³. Clearly clients who have more complex and longstanding problems are more likely to benefit from more sessions than Better Access currently provides.

(e) mental health workforce issues, including:

(i) the two-tiered Medicare rebate system for psychologists,

This has certainly been a divisive issue for psychology, in part because of the quantum of difference in payments between clinical and general psychologists, but also because other specializations within psychology are not equally remunerated. There is a good argument to include college members of; health, neuropsychology, education and developmental, and counseling into the higher rebate as all of these areas can also make specialist contributions to helping clients referred under Medicare. The APS also needs to fast track the work they are doing currently on helping other specialist psychologists to move from one specialization to another. Currently these highly trained professions are being remunerated at a level that does not reflect the level of skill and expertise they have acquired.

Much has been made of the equivalence of outcomes found between clinical psychologists and registered psychologists in the Better Access review. In some quarters this has been used as an argument to dismantle the two-tiered system and replace it with a single rebate for all psychologists.

However, before accepting that conclusion the data presented needs to be carefully considered. Forty-one clinical psychologists, and Forty nine registered psychologists self selected for inclusion into a small study. These psychologists then self-selected 5 to 10 clients to participate in the study. There was no random selection of clinicians or clients. The clinical improvements observed in both groups were comparable, however these data are not representative of what would be expected in a clinical outcomes study.

Cohen's D is a standard statistic that can be used to compare total change

³ Howard, K., Kopta, M, S., Krause, M, S., & Orlinsky, D, E (1986). The dose effect relationship in psychotherapy. *American Psychologist*, 41 (2), 159 -1164.

from clinical intervention⁴. My calculations of effect size obtained in the Better Access evaluation data suggest an average Cohen's D of 1.15 (a very large effect). Most clinical research suggests that good psychotherapy is more likely to achieve a Cohen's D of around 0.68⁵. This suggests that the group of clients in the evaluation achieved outcomes nearly 100% better than the research literature would suggest is likely. One possibility is that this was a group of exceptional therapists; the other is that this was a group of the most successful therapy cases, not balanced out by the least successful.

No one would reasonably expect that the best work done by the best clinical psychologists would be any better than the best work done by the best registered psychologists. There is a limit to how much "better" a client can actually get. The two more interesting questions are;

1. Does the average client treated by the average general psychologist achieve the same gains as the average client treated by the average clinical psychologist?
2. Does the complex and challenging client do as well with a general psychologist as with a clinical psychologist?

The Better Access evaluation does not speak to either of these questions, and the authors themselves acknowledge that their evaluation can inform the debate into the differences between these two groups in only a limited way.

There is no question in the literature that some therapists are more effective than others. A naturalistic study of over 500 therapists and 6000 clients showed a consistent difference between the most effective and the least effective practitioners⁶. However this research was unable to identify specific characteristics of therapists who were more effective. There is some limited evidence that masters training improves the ability to assess, diagnoses and formulate complex cases⁷. However, the most convincing data on how to improve therapy outcomes for clients is through regular measurement and

⁴ Cohen, J. (1969). *Statistical Power analysis for the behavioral sciences*. NY Academic Press.

⁵ Smith, M, L., & Glass, G, V. (1977) *Meta-Analysis of Psychotherapy outcome studies*. *America Psychologist*.

⁶ Wampold, B. E., & Brown, G. S. (2005). Estimating therapist variability: A naturalistic study of outcomes in managed care. *Journal of Consulting and Clinical Psychology*, 73, 914-923.

⁷ O'Donovan, A., Bain, J. and Dyck, M. (2005). Does a clinical psychology education enhance the clinical competence of practitioners? A controlled trial. *Professional Psychology: Research and Practice*, 36(1), 104-111.

feedback to therapists on client progress using objective measures⁸. From my observation, it seems that not nearly enough psychologists or clinical psychologists are engaged in regular measurement and assessment of their clients. However, from observation alone it seems that more of my clinical colleagues than my general colleagues are engaged in this level of self monitoring and development. But clearly there is insufficient available data to make this observation definitively.

The current two-tier system is endorsed by the APS, and is accepted within the psychological community as representative of a specialised mental health training standard. It also is consistent with other first world countries in their training standards. Moving towards this two-tiered system has been a 30 year process of workforce planning both for the profession and for the Australian Government. It seems ill informed to reverse this policy direction based on the findings of one small-scale study that simply showed that both groups are capable of doing good work.

However, the suggestion that a single training standard might be equivalent is certainly economically attractive if it were true. It seems worthwhile to invest in additional mandatory measurement of the Better Access program in order to gather data from all clients treated by all psychologists so that a true comparison can be made. But more importantly, so that the latest research on outcomes feedback can be used to ensure that all therapists are achieving better outcomes for their clients.

⁸ Lambert, M. J., Harmon, C., Slade, K., Whipple, J. L., & Hawkins, E. J. (2005). Providing feedback to psychotherapists on their patients' progress: Clinical results and practice suggestions. *Journal of Clinical Psychology*, 61, 165-174.