Seed Psychology Pty Ltd

25 July 2011

Committee Secretary
Senate Standing Committees on Community Affairs
Att: Community Affairs References Committee
PO Box 6100, Parliament House
Canberra ACT 2600

Dear Senate Committee members

RE: Senate Committee Inquiry – Commonwealth Funding and Administration of Mental Health Services – Reduction of Medicare psychological sessions, and the two-tier system.

Thank you for this opportunity to raise our concerns regarding recent changes to the Better Access to Mental Health Scheme introduced in the 2011-2012 Budget, and the lobbying by an organisation to remove the two-tiered Medicare Rebate system for psychologists. Seed Psychology is based in Melbourne and comprises five clinical psychologists with significant experience in treating clients with mental health disorders, in both hospital and private health settings. We are highly concerned that the decision by the federal government to reduce Medicare-rebate eligible clinical psychological treatment sessions from 12 sessions (18 sessions in exceptional circumstances) to 10 sessions will have a significant detrimental impact on the welfare and treatment of clients with mental health issues, and in particular those with complex presentations. In addition, we would like to make clear our strong support for the retention of the two-tiered Medicare rebate system for psychologists, which recognise the distinct services provided by clinical psychologists who are specialised in the assessment, diagnosis and treatment of people with mental health disorders through their possession of advanced education and training in this field.

1. <u>Concerns regarding the reduction of Medicare-eligible psychological sessions under the Better Access Scheme from 12-18 sessions to 10 sessions</u>

We are concerned that psychological services under the Better Access Scheme will now fall short of best practice guidelines for minimal treatment. Our concerns are further outlined below:

(a) Although the government has announced programs for the severely ill and persistently mentally ill these programs exclude many people who are currently treated by clinical psychologists, and will significantly impact the access to effective psychological treatment in this country. This is particularly disheartening, as for the first time in Australia, the Scheme allowed Australians, regardless of income, to have access to effective, evidence-based psychological care.

(b) Our overall ability to provide effective mental health treatment will be unjustly compromised under the new system. Ten treatment sessions per year is not sufficient to treat most mental health disorders. Indeed, evidence-based practice suggest 10 to 20 sessions of treatment is required to effectively treat common mental health disorders. We are concerned that those clients with moderate to severe mental health disorders will now be denied essential care.

(c) In April 2011, a review of the Better Access Scheme was released by the federal government, indicating that the Scheme was very effective in reaching people with moderate to severe mental health disorders, whilst providing them with cost-effective treatments. Prior to the introduction of the Better Access Scheme, many of these clients would not have been able to access support due to cost-prohibitive psychiatric treatment, or be eligible for assistance through an over-burdened public mental health case-management sector. In this case, we question the decision of the federal government to reduce psychological treatment sessions for these vulnerable clients. Without receiving adequate care through the Better Access Scheme, many Australians will not receive the support and treatment they need to improve their mental health and contribute to the workforce and wider community.

(d) Although the April 2011 study conducted by Melbourne University reported that the majority of clients accessed a psychologist between one and six sessions, this has not been our individual experiences. As a clinical psychology practice we are referred clients with complex presentations whom require lengthier, more intensive treatment. Prior to the proposed budget reductions, these clients had been eligible for up to 18 sessions under the exceptional circumstances provisions in the Better Access Scheme. Under the proposed Scheme, these clients will no longer be able to receive essential and affordable psychological care due to the significant reduction to ten sessions only. This raises serious ethical concerns in regards to commencing treatment with clients who suffer severe mental health disorders, due to the insufficient session allowance. This will place both clients and clinical psychologists at risk

(e) We also note inaccuracies in federal government policy statements regarding mental health treatment for those clients requiring more than ten sessions. These policy statements state that these clients would be more effectively treated by a psychiatrist. This is an inaccurate assumption and does not reflect current best practice in the mental health sector. Current best practice supports psychiatric and psychological treatment in conjunction; not as an either/or choice. Our clinical psychological practice receives many referrals from private psychiatrists (who are prescribing psychotropic medication) for psychological treatment. Psychological treatment in these cases forms an integral component of the client's overall mental health treatment.

As highlighted above, there are significant issues associated with the planned cuts in funding to the Better Access Scheme. We advocate for the reinstatement of 12 Medicare-eligible sessions (18 in exceptional circumstances) per year to ensure that the most vulnerable Australians are provided with affordable and essential assistance to improve their wellbeing and capacity to work and contribute to Australian society.

2. Retention of the two-tiered Medicare rebate system that recognises the specialised treatment provided by clinical psychologists for clients with moderate to severe mental health disorders.

We strongly advocate for the retention of the current two-tiered Medicare rebate system. The current system recognises that clinical psychologists have accredited post-graduate qualifications, training and experience in the assessment and treatment of complex and severe mental health disorders. We have completed a period of training similar to that of psychiatrists, and have worked in both hospital and community case-management settings. The current scheme distinguishes two types of services available to clients: *Clinical Psychology Services* provided by a clinical psychologist; and *Focused Psychological Strategies* provided by allied health professionals which includes Psychologists, Social Workers and Occupational Therapists. While *Focused Psychological Strategies* may be well-suited to clients with mild mental health disorders, *Clinical Psychology*

Services are required to meet the needs of clients with moderate to severe mental health disorders. This means maintaining, at a minimum, the 12 to 18 sessions per year currently available through the Better Access Scheme. We have become aware of the recent actions and statements of a small group of disaffected psychologists that have argued for the removal of *Clinical Psychological Services* under the Better Access Scheme. We understand that this organisation is lobbying the federal government to lower standards for clinical psychology in order to enable them to access the responsibilities and privileges inherent in the specialisation without undertaking the requisite training. We reiterate that the professional responsibilities, demands and expectations on clinical psychologists are very high in treating the most vulnerable members of Australian society. As such, it is the best interests of public protection not to reduce standards further by allowing unqualified and untrained psychologists entry to the speciality.

Previous Australian research studies support the clear distinction between the wider range and higher quality of assistance provided by clinical psychologists to clients with severe mental health disorders. The Review of Clinical Psychology Services conducted by the Management Advisory Services to the NHS, May 1989, stated that:

> *The range of psychological skills possessed across the various disciplines can be located within a skills framework related to three levels of activities:*
>
> *Level 1* — *basic "psychology" - activities such as establishing, maintaining and supporting relationships with patients and relatives, and using some simple, often intuitive techniques, such as counselling and stress management.*
>
> *Level 2* — *undertaking circumscribed psychological activities (such as behaviour modification). These activities may be described by protocol. At this level there should be awareness of the criteria for referral to a psychologist.*
>
> *Level 3* — *activities which require specialist psychological intervention, in circumstances where there are deep-rooted underlying influences, or which call for the discretionary capacity to draw-on a multiple theoretical base, to devise an individually tailored strategy for a complicated presenting problem. Flexibility to adapt and combine approaches is the key to competence at this level, which comes from a broad, thorough and sophisticated understanding of the various psychological theories.*

Clinical psychologists are the only profession which operates at all three levels. It is the skills required for level 3 activities, entailing flexible and generic knowledge and application of psychology, which distinguishes clinical psychologists from other disciplines.

Further information is detailed in *Towards A More Efficient & Effective Mental Health Service In Nsw Health: The Development Of An Effective Clinical Psychology Workforce*, prepared by Dr. Phil Renner & Professor Alex Blaszczynski (2004):

> *Stepped care models have the potential to deliver effective and cost efficient treatments (in terms of both money and human resources) to large numbers of people. For example, instead of delivering standard protocol driven CBT to all patients, Williams (2001) recommends that CBT treatments should be delivered across three levels:*
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> - *Level 1: Treatments should be routinely initiated by the provision of brief therapies such as self-help, delivered, for example, as structured written self-help or computer-based materials. These treatments could be widely offered in primary care alongside the wide range of self-help provided by voluntary sector groups and organizations*
> - *Level 2: Where the person has more severe or complex problems, or is at risk, more intensive therapist guided packages of care should be provided*

- *Level 3: For more complex or treatment resistant cases, full specialist CBT could be offered by experts.*

Focussed Psychological Strategies fit within level two of this model and require less advanced training to be applied effectively. More chronic presentations and those with more severe mental health disorders require greater expertise to assess, diagnose, formulate and treat effectively. They also require longer treatment periods with the integration of advanced therapies and approaches. Only clinical psychologists and psychiatrists have the level of advanced training to undertake this provision of service at level three. The treatments provided by clinical psychologists and psychiatrists frequently complement each other in providing sound psychological and medical management of mental illness and psychiatrists and clinical psychologists frequently work closely together to manage patients. With the shortage of private psychiatrists and the high co-payments required for their services, clinical psychologists are needed to supplement the workforce in all domains to provide appropriate these services to patients. Currently, only the Better Access program enables clinical psychologists to provide tailored programs for those with more severe or complex presentations at level three within the private health system.

The federal government has also stated that clients who required more than ten sessions under the proposed changes would be more effectively treated under the Access to Allied Psychological Services (ATAPS) program, the public health system, or from private psychiatrists. However, we note that there are significant issues and impediments for clients with moderate to severe mental health disorders to receive assistance through these avenues. The ATAPS program is restricted to the provision of *Focused Psychological Strategies* that can be delivered by non-clinical psychologists and other allied health professionals. However, we reiterate that clients with severe mental health disorders require services provided by those specialists with advanced knowledge of assessment, diagnosis, formulation and treatment modalities of mental health issues, such as clinical psychologists and psychiatrists. These services are not provided for under ATAPS.
We have been advised by the Australian Clinical Psychology Association (ACPA) that much of the newly announced ATAPS funding is for the Tier 3 funding ("severe and persistent" mental illness). In turn, ACPA has been advised by the College of Clinical Psychologists of the APS that, once programme-related overhead and administrative costs are deducted, there remains only provision for an approximately 0.8 EFT salaried clinical psychology position within a Division that can be dedicated to the Tier 3 program. Given the additional cost of employment of clinical psychologists, many Divisions choose to employ less qualified psychologists at a lesser cost. Thus, to have those with more moderate and severe presentations treated under ATAPS, means to have the more vulnerable treated by a workforce without specialist qualifications and training, utilising short-term strategies.

It is also important to note that Australian industrial relations tribunals also recognise the difference between Clinical Psychologists and generalist psychologists, and this legislatively recognised difference is enshrined in awards, which not only lay out different pay scales, but also lay out the differences in skill sets and the kind of work done by these groups.

In summary, we are highly concerned that the reduction in Medicare-eligible psychological treatment sessions from 12-18 to ten sessions, as well as the removal of the two-tiered system that recognises the value-adding and specialised assistance provided by clinical psychologists, will negatively impact on the treatment of clients with moderate to severe mental health disorders, who comprise the most vulnerable members of Australian society. We strongly advocate for the retention of 12-18 sessions and the two-tiered system, in order to provide vulnerable Australians with the most effective treatment options in order to improve their wellbeing and contribution to Australian employment and society.

Yours sincerely,

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