27th July, 2011

Submission to the Senate Committee's Mental Health Inquiry into the Government's 2011-12 Budget changes relating to mental health services in Australia

Terms of Reference 2d.
The impact of changes to the number of Allied Mental Health treatment services and
Terms of Reference E (i) – Mental health workforce issues, including:
The two-tiered Medicare rebate system for psychologists

I am a clinical psychologist in private practice in a busy medical centre where I bulk bill most patients as they are in a low socio-economic bracket. The majority of patients are referred to me as 'Urgent' because local mental health centres are overwhelmed (e.g., the patients have been released from hospital but still require ongoing psychological therapy), or due to the severity and complexity of their presentations to their medical practitioners, paediatricians, and/or psychiatrists. Many of these patients have complex underlying issues that need to be quickly unravelled, in many instances to preserve life. In 2009 suicide was the 14th highest cause of death (10th highest in males) and accounted for 25% of males between 15 and 24 years old (Bureau of Statistics, 3303.0.Causes of death, Aust. 2009). Clinical Psychologists are specialists in mental health and are more readily available and affordable than the other specialist in mental health, i.e. psychiatrists. Therefore, the proposition that sessions for Psychologists (which appears to include Clinical Psychologists, although this was not differentiated) be reduced and that Clinical Psychology no longer be recognised by a higher rebate is concerning.

Re: Terms of Reference 2d
My first concern is the reduction of sessions from 12 to 10 with no provision for additional sessions. It is my opinion that 10 sessions per year is sufficient for mild to moderate mental illness cases, however it is against evidence based practice to commence treatment on a patient for instance with Post Traumatic Stress Disorder as the optimal number of sessions for this disorder is between 16 and 20 sessions. That does not mean over a two year period, it means the sessions need to be regularly spaced. For example, 6 sessions weekly, then perhaps fortnightly, with regular (monthly) follow up to avoid relapse and to consolidate and build on gains made. If we resort to seeing these patients for 10 sessions, then we risk major relapses with a long gap before they will be eligible to see the practitioner again. What happens if that patient becomes suicidal – ethically, how could we refuse to see them if they had no way of paying? What happens if a patient with Depression is discharged in June due to utilising their 10 sessions and then in October their child dies, or some tragedy befalls them and they want to re-commence psychological treatment, yet they are unable to pay for a visit? Can we ethically ask them to wait 6 months, is this not like telling a patient with an infection they are out of visits for the year, and we cannot treat you for 6 months.

There is some disparity once sessions are reduced to such a small amount. A patient who is very unwell in the latter part of the year has quite an advantage over a patient who falls unwell in January. The latter patient will be able to see the psychologist for 10 sessions only (say fortnightly, not optimal, but feasible) for 6 sessions and then 4 follow up – maybe January until June. Whereas the patient who falls unwell in January is likely to run out of sessions, once the additional sessions in extenuating circumstances is removed.

Medical Practitioners were provided with the leeway to offer a further 6 sessions for extenuating circumstances, after all they are in a position to know when this is required. Some leeway for extenuating circumstances needs to remain for the reasons stated and many others not delineated here.

Terms of Reference E (i)

My second concern is that the Senate Committee does not recommend that the difference between Psychologists and Clinical Psychologists be recognised, either conceptually, within the industry, or financially. Yet Clinical Psychology is recognised conceptually (e.g., Masters Programs offered at Universities). Australia is one of the few countries that allow Psychologists to practice without a Post Graduate Degree. In a bulletin of 'In Psych', (April, 2007) it was written that "no other country surveyed in a review (New Zealand, UK, USA, and Europe) permits registration of Psychologists without a professional postgraduate degree" (p.13).

In 1989 the Management Advisory Service to the NHS differentiated the health care professions according to skill levels and defined three levels of skills as follows:

Level 1 – Basic Psychology – activities such as establishing, maintaining and supporting relationships, use of simple techniques (relaxation, counselling, stress management)

Level 2 - Undertaking circumscribed psychological activities (e.g., behaviour modification)

Level 3 - Activities which require specialist psychological intervention, in circumstances where there are deep rooted underlying influences, or that draw on a multiple theoretical base, to devise an individually tailored strategy for a complex 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.

The group suggested that almost all health care professionals use level 1 and 2 skills and some have well developed specialist training in Level 2 activities. The group went on the argue that Clinical Psychologists are the only professionals who operated at all three levels and "it is the skills required for level 3 activities, entailing flexible and generic knowledge and application of psychology, which distinguishes clinical psychologists...."

Clinical psychology is one of nine equal specialisations within psychology. These specialisations are recognised internationally, are enshrined within Australian Legislation and are the basis for all industrial awards. They have been recognised since 1965 and it is the West Australian model which formed the basis for the 2010 National Registration and Accreditation Scheme recognition of specialised areas of endorsement. It is my opinion that each specialist area should be covered by their own Medicare rebate, however that is not the topic of discussion here.

Clinical Psychology is also recognised within the industry, although there have been recent submissions made from some Generalist Psychologists who are upset by the difference. However, removing the two-tiered Medicare rebate is not the answer (see further remarks below). Also, there is a financial cost to having obtained a Masters Degree, not only in terms of the fees, but in terms of the two years full time post graduate study that is required, i.e. 6 years full time in all. This is followed by 2 years (previously 1 year) of supervised practice wherein certain competencies have to be met. Therefore 8 years training in total.

Medicare accepted that for a Clinical Psychologist to be paid as a specialist they had to meet the criteria that is required to be accepted into the Clinical College. There are a number of ways to be accepted into the Clinical College to receive specialist endorsement. Therefore if 'deemed' Generalist Psychologists believe they meet the specialist criteria then they should apply.

The diversity of psychology should be honoured to also ensure that individuals train as specialists in the future. The integrity of those who have trained as specialists, should also be protected and these individuals should also be paid accordingly.

Of concern is that the committee appears to have rested largely on the Better Access Survey rather than a deeper understanding of scientist practitioner model of Clinical Psychology and all it entails.

Limitations of the Better Access Survey

Yet, the Better Access Survey has too many limitations to support that the level of skills of Clinical Psychologists should be dismissed as being no different to those of a Generalist Psychologist. The participation rates in that survey were just 8% for Clinical and Registered Psychologists. At just 8% this questions if the findings can be generalised (only 41 Clinical Psychologists and 49 Registered Psychologists participated). Further the study did not meet some fundamental standards of research design (e.g., the nature, diagnosis or complexity of the clients seen by psychologists by type of psychologist, and medication adherence was not controlled for, nor was the study subjected to a peer review. Further, the study was a self-selected sample of psychologists with no control measures to ensure the type of patients those psychologists selected, and with no controls on the administration of the questionnaires.

Additionally, there are major limitations set by the outcome tools used. For instance the DASS, which has been used extensively within the survey to show outcomes, is a questionnaire which the patient completes based on their symptoms for Stress, Anxiety, and Depression within the previous 7 days. Symptoms fluctuate, and a patient can have a week where they function within normal population ranges, yet not be stable and if surveyed a week later may be quite unwell. There has been no measures for relapse rate differences between the two-tiers. Further, there were 883 pre treatment measures taken, and only 590 post treatment measures obtained for a number of reasons, part of which is that some of those measured had not yet completed treatment. Also, the DASS is not a suitable outcome measure for many individuals with severe mental illness, such as psychosis or mania. For instance a patient with mania may score with no clinical symptoms on a DASS, as they believe they are functioning well, yet require hospitalisation. These are only a few instances of how this questionnaire cannot inform accurately the wellbeing of a patient.

Recommendations

The two-tiered Medicare rebate system should remain, however it is my opinion that there are Generalist Psychologists and other endorsed specialist Psychologists who may be eligible to receive specialist status in recognition of their skills and the time and study they have contributed towards providing higher levels of evidence based practice to their patients. It may be more appropriate to recommend those practitioners seek to be raised to the top tier, then to remove the top rebate tier.

I urge the committee to reconsider their conclusions on two accounts, firstly with regard to the decrease in sessions, especially for complex mental illness and secondly that the committee recognise the difference between Clinical Psychologists, conceptually, within the industry, and financially and leave the two tier rebate in place.

Yours Sincerely,

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