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## **Submission to Senate Inquiry into the Commonwealth Funding and Administration of Mental Health Services**

We are grateful for the opportunity to submit information and comment to the Senate Inquiry into the Commonwealth Funding and Administration of Mental Health Services. We are clinical psychologists and regularly provide services to patients referred under the Better Access Scheme. Our submission relates to the following terms of reference:

- (b) changes to the Better Access Initiative, including:
  - (ii) the rationalisation of allied health treatment sessions,
  - (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.
- (e) mental health workforce issues, including:
  - (i) the two-tiered Medicare rebate system for psychologists,
  - (ii) workforce qualifications and training of psychologists

We endorse the submission prepared by the Australian Clinical Psychology Association (ACPA) which we have contributed to in our role as ACPA Board Members. We wish to provide additional information and comment regarding the above specific terms of reference.

### ***Changes to the Better Access Initiative***

Under the changes proposed in the Federal Budget, the number of clinical psychology treatment sessions a person with a mental health disorder can receive each year will be reduced from a maximum of 18 down to 10. The Government has argued that the changes to the Better Access Scheme will not affect large numbers of consumers, as only 13% of Better Access patients receive more than 10 sessions. Additionally, the Government has argued that "It is important that people get the right care for their needs. People who currently receive more than 10 allied mental health services under Better Access may have more severe or complex needs and would be better suited for referral to more appropriate mental health services."

We would argue that clinical psychologists in private practice and in the public sector are specifically trained to provide "appropriate" care for patients with "more severe or complex needs". Clinical psychologists with accredited post-graduate qualifications in the speciality have specialised training and experience in the assessment and treatment of mental health disorders, across the spectrum of mild, moderate and severe presentations. The Government has overlooked this fact and has argued that people who require over 10 psychology sessions per year are better cared for by: (1) the public

mental health system; (2) private psychiatrists; (3) the Access to Psychological Services Program (ATAPS). Specific concerns about these alternatives have been outlined in the submission prepared by the Australian Clinical Psychology Association.

We are concerned that the Government decision is not guided by a thorough understanding of existing clinical referral pathways. Currently, we regularly receive referrals from psychiatrists to provide clinical psychology services for their patients, working collaboratively with the psychiatrist as they provide ongoing psychiatric review and medication management. This includes referrals for patients whom the Government would likely define as having “severe” and/or “complex” needs. The referral pathway also works in reverse, as is the case at our clinic where we have a consulting psychiatrist who treats patients being seen by our clinical psychology team who require psychiatric care to complement their clinical psychology care. Clinical psychologists and psychiatrists have a long history of working collaboratively in the private and public sectors. This will often involve the clinical psychologist providing regular therapy, while the psychiatrist provides less frequent review sessions to support adherence to medication regime and make changes to medication as required. The Government has failed to recognise or acknowledge the importance of these collaborative relationships and combined care of patients with “severe” and/or “complex” needs, and the fact that psychiatric care is not a direct substitute for clinical psychology care.

In addition, clinical psychologists in private practice regularly receive referrals from local public mental health teams, community health and public hospitals. Typical referrals include: patients who have been managed by the mental health team during the acute phase of their illness and require additional clinical psychology services to address ongoing symptoms and prevent relapse; patients with personality disorders who repeatedly present to public mental health due to self-harm behaviours and/or suicidal ideation/attempts and require ongoing, intensive clinical psychology services. To the best of our knowledge the Budget changes have not resulted in additional funding of public health services to the extent that would be required to allow these already stretched public services to provide for ongoing clinical care of patients whom they would normally refer to private providers for longer-term and/or non-acute care under the Better Access Scheme.

Indeed the Government’s plans broadly ignore the value of the existing referral pathways and coordinated care processes that have been established prior to and built on further following the commencement of the Better Access Scheme. These referral pathways and coordinated care arrangements have taken years to establish and we believe they have broadly served patients well. In the ten years during which our private practice has been in operation we have established excellent relationships with local public health services, GPs, psychiatrists, obstetricians and other specialists, child and family services, schools, and private hospitals. These services have referred patients to our practice with “severe” and/or “complex” needs. Now the Government is suggesting that these referral processes are not the most appropriate option and therefore these valuable referral pathways and established services for the community will be lost.

The Government’s rationale for their decision to reduce the number of available sessions ignores the simple fact that it is the most vulnerable patients who will be impacted on the most. As clinical psychologists we are routinely referred patients with moderate-severe primary mental health diagnoses and comorbid personality disorders, substance abuse, and early trauma histories. We see patients with long-standing and/or severe mental health issues and associated impairment in functioning, adults presenting with childhood-onset anxiety disorders, patients with eating disorders, and patients with chronic depression that has not responded to medication. The current provisions for 12-18 sessions per calendar year for these patients are in themselves inadequate, and not grounded in evidence-based practice. To restrict these services further is deeply concerning. The proposed revised scheme will reduce the quality of service and in many cases will make such work untenable and potentially unethical. Treatment of the patients described above under the 10 session

scheme may have unintended negative consequences as the reduction in the number of available sessions will likely require that treatment be interrupted or ceased prematurely. Such treatment interference may result in: symptom exacerbation or relapse; treatment aversion; reinforcement of long-standing patterns of isolation, rejection/abandonment and hopelessness, particularly for individuals with trauma or personality disorder presentations. For these reasons we have serious concerns regarding the ethics of providing treatment to such patients referred under the Better Access Scheme if the new session limits are to be implemented. Put simply, clinical psychologist will not be able to ethically and effectively treat many of the patient groups commonly referred.

We are also concerned that the Government has not given consideration to the varied reasons for a patient requiring more than 10 therapy sessions with their treating clinical psychologist. Under the current scheme which the Government seeks to change, patients are able to access 12 sessions per calendar year and an additional six sessions under “Exceptional Circumstances”. The new scheme removes the option of referral for additional sessions under Exceptional Circumstances. This option was seen as a vital inclusion in the original Better Access Scheme and this provision has been potentially available for all patients, including those with mild, moderate and severe initial presentations. It has allowed patients to access continuity of care from their clinical psychologist where they have completed their allocated 12 sessions in the calendar year, but require further treatment in the context of a significant change in their clinical condition or care circumstances. For example, such changes could include, or experiencing a significant trauma, loss, or relationship breakdown resulting in (the development of) significant additional mental health symptoms. We believe that in most cases the treating clinical psychologist is best-placed to provide additional care to such patients, as they are already familiar with the individual, do not need to undertake a full review of patient history, and can draw and extend on skills the patient has already developed in therapy to assist them in coping with the change in their clinical condition or circumstances. The Government’s suggestion that all such patients are best referred on to other another provider from a “more appropriate” service (psychiatrist, public mental health or ATAPS) undermines the importance of continuity of care, and highlights fundamental gaps in the understanding of the clinical operation of the current Better Access scheme.

### **The two-tiered Medicare rebate system for clinical psychologists and psychologists**

The two-tiered Medicare rebate system for clinical psychologists and psychologists recognises the value of APAC accredited postgraduate training in clinical psychology and the additional period of supervised practice that clinical psychology registrars must undertake on completion of this training. The two-tiered system differentiates the services provided by clinical psychologists and other allied health providers in two primary areas: (1) The type of therapies that may be used; (2) The amount of the rebate paid. With regards to the first point of difference, the Clinical Psychology Items allow the provider to select evidence-based treatments to be used with the patient based on clinical relevance. In contrast, the items for other allied health providers are restricted to the provision of specific Focused Psychological Strategies. This distinction would be presumed to be based on the recognition that clinical psychologists undergo extensive and intensive training in the application of a range of evidence-based psychological therapies for patients with mental health problems, and are trained to select appropriate treatments based on the patient’s presenting problem. The differential rebate is presumed to reflect both the level of skill required to undertake clinical assessment and deliver carefully selected evidence-based therapies of varying complexities, and the additional qualifications and training completed by clinical psychologists. These pay differentials for clinical psychologists relative to psychologists and other allied health professionals are also found in the public sector, as well as in pay rates set by non-government organisations. Higher pay for higher qualifications and training is considered to be the standard across most if not all professions.

As noted above, the Medicare Clinical Psychology Items are qualitatively different from the Focused Psychological Strategy items, with clinical psychologists permitted to utilise a broader range of clinician-selected evidence-based treatment strategies. It is not clear as to why the Government, in determining the proposed Budget changes, has in fact made no direct mention of changes to Clinical Psychology Items, but instead appears to have ignored vital distinctions and grouped the Clinical Psychology and Focused Psychological Strategy Items together. This has certainly added to our concerns that the Budget changes were poorly considered and based purely on fiscal considerations, not on quality of service provision and patient care.

There has been significant debate within the profession of psychology in relation to the differentiation of clinical psychologists from generally registered psychologists who do not hold endorsement in the area of clinical psychology. In this process, accusations have been made that clinical psychologists are denigrating the skills of their psychology colleagues. We do not seek to denigrate the skills of any professional, but simply wish to state our view that APAC accredited Masters and Doctoral-level training in Clinical Psychology provides the highest levels of training currently offered within our profession in this country. Doctoral-level postgraduate training is considered a minimum standard for registration in other western countries. These courses are designed to ensure that all core areas of clinical practice are addressed, including assessment, diagnosis, case formulation, and evidence-based treatment planning and implementation. Clinical placements for students are provided across a range of mental health services and offer intensive supervision by university-approved supervisors. Following completion of the degree, clinical psychology registrars undertake an additional 1-2 years of supervised clinical practice before being eligible for endorsement in the area of clinical psychology by the Psychology Board of Australia. This four-years minimum postgraduate training is quantitatively and qualitatively different from the two-years of supervised training completed by registered psychologists who do not meet criteria for endorsement by the Psychology Board of Australia.

### **Lack of consultation with clinical psychologists**

We have been deeply concerned about and frustrated by the lack of consultation with private clinical psychology providers, given the substantial changes that have been proposed to Better Access Scheme. Clinical Psychologists possess extensive training and experience in mental health care and we believe have the capacity to provide the Government with invaluable information and guidance to inform mental health care policy. The Government claims to have developed their policy changes based on extensive collaboration, but the lack of consultation with private clinical psychologists highlights significant gaps in these processes.

### **Further comment regarding the delivery of psychological services under Medicare**

We have serious concerns about the past operation of the Medicare system for clinical psychologists, where determination of eligibility for provision of Medicare Clinical Psychology services has been the responsibility of the Australian Psychology Society (APS). This has allowed the APS to assess some psychologists as eligible to provide clinical psychology services without the requirement of completion of an APAC accredited degree in Clinical Psychology. The current system requires that clinical psychologists continue to submit their professional development information to the APS in order to maintain eligibility as Medicare clinical psychology providers. The APS also has responsibility for assessing eligibility for other specific Medicare items such as psychological services for children with Autistic Spectrum Disorders. Psychologists who are not Members of the APS are required to pay fees to the APS for assessment of eligibility, while these fees are waived for APS members. Professional associations are established to work in the interest of their members. We do not believe

that a professional association should be given the role to undertake assessments of eligibility for Medicare service provision, or assessment of professional development activities undertaken by clinical psychologists. We believe that this role should be given to the Psychology Board of Australia or another accredited body.

We thank the Senate again for the opportunity to make this submission, and trust that the information we have provided will assist the Senate in this important undertaking.

Yours sincerely,

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