

July 30 2011

**To the Members of the Senate Community Affairs Reference Committee  
Into Commonwealth Funding and Administration of Mental Health Services**

This submission is written in response to the changes to the Better Access Initiative and challenges to the current system, including:

**A)** The rationalisation of allied health treatment sessions - being cut from a Maximum of 18 down to 10

**B)** The current Medicare rebate system for psychologists

**1. The rationalisation of allied health treatment sessions - being cut from a Maximum of 18 down to 10**

According to the Government claims advising that very few people access more than 10 sessions under the Better Access program, what is the point of cutting a system that is working. Would there be significant cost savings. Those that access these programs, the consumer, are going to be restricted from accessing more than 10 sessions under these new arrangements.

The Department of Health and Ageing commissioned a review of research regarding the necessary length of psychological treatment for various mental health disorders, using taxpayer funds. How is this good application of funds when the review was dismissed in favour of the findings of a single uncontrolled study with no long term follow-up?

Psychologists recognise that the problems faced by over 80% of consumers utilising the Better Access program are struggling with moderate to severe mental health disorders. Then two independent studies confirmed this finding. Why are they being offered such limited inappropriate lengths of treatments, remembering that the Governments findings support the level of mental health disorders that are being treated for over 80% of the Better Access population?

Appropriately Governments want to gain the most for each dollar spent. Consider this, if a patient seeks help from a Psychologist under the new system and they present with a more serious or complex mental health issue, they are then required to utilise the ATAPS program for further psychological support and treatment.

These ATAPS programs will have different psychological service providers to those in the Better Access program. These already distressed consumers will then have to begin the therapeutic process all over again with a new mental health professional. It takes time for someone with a mental health disorder to learn to trust and to feel that they can explore their issues, while the therapist takes time to establish a safe and caring therapeutic environment. This will take time, and will cost many more dollars than allowing the initial therapist to continue the work that they have started. Disruption in therapy can have a very negative and destructive effect on the outcomes for a mentally ill person.

When people who have a mental health disorder receive inadequate treatment they often can end up in hospital or struggle with a range of related problems associated with their mental health disorder. This can include issues with employment, family and health. How can 'Better Access' live up to its name when services are being cut and a stay in a Psychiatric hospital costs thousands, the system is working and it is cost-effective.

I urge you to maintain the current number of sessions of psychological treatment that a person with a mental health disorder can receive for each calendar year. I urge you to retain the working system as it is now allowing patients to receive a maximum of 12-18 per year. I again make reference to the recent evaluation of the Better Access initiative's findings that this service has a significant positive outcome for improved psychological wellbeing and that this service surpassed positive predictions about the scheme by a wide margin. Existing services are working well to improve the psychological wellbeing of Australian's and changes that deplete the service that has proven itself to be effective is at a great cost to the citizens of Australia.

The plan to cap sessions for psychological treatment at 10 sessions falls below standard treatment protocol for the management of even the most uncomplicated psychological conditions. See research conducted by Harnett, O'Donovan and Lambers (2010) as evidence and support for maintaining the current number of sessions available. They show that for 85% of people to show clinically significant change in their severity level of symptoms, around 20 sessions of treatment are required. This supports our argument that reducing the available continuity of treatment at 10 sessions will put patients at risk, and may very well decide not to continue with treatment if they have to go elsewhere, this would be shameful. Any changes to address the gaps in our health system must not come at the cost of programs in, mental health care that have been shown to be effective.

## **2. The current Medicare rebate system for psychologists**

As a Psychologist who is not a member of the Clinical College, I feel very strongly that certain groups in the Clinical College have made some derogatory and bogus claims in support of the two tier rebate system for psychologists. These points briefly are:

1. That there is a "vast difference" in the training of clinical psychologists and every other mental health professional

I feel it is important to clarify and clear up this misnomer. The first 4 years of psychologist education is shared by all psychologists. The overwhelming majority of clinical psychologists are masters degree qualified, which amounts to 2 years additional training. The APS and APAC estimate 70-80% overlap in the course content across accredited specialist training courses in psychology. Hence, the most of the post-grad training covers similar ground.

A colleague has made this a crude calculation, if we take each semester to be 12 weeks, then 2 years of training amounts to 50 weeks of training. If we take 80% of those weeks as being shared content across specialist courses, then we have 40 weeks out of those 50. Returning to the 12 week term, the 10 remaining weeks end up being less than a single term. So how vast are the differences in the training? Not so vast at all.

Clinical Psychologists may of course argue that the 3 placements they do in the degree are vastly different, as well as the 2 years of supervised practice that follow. Starting with placements, every post-grad course competes for getting Masters/PhD students on placements, so clinical psychology courses are not distinctive in the settings where they get placement. Sometimes they get access to in-patient hospital settings where other students don't, but that is not the focus of the Better Access scheme in the first place.

The reality is that in the last few decades there has been an increasing focus on psychological services being treated out in the general community, which has meant that psychologists who work out of the in-patient hospital system now see more complex, chronic and severe cases. Therefore, in practically every setting in the general community we are seeing complex cases. The question is really whether the psychologist in question is performing assessment, diagnosis and treatment functions - and a lot of practitioners besides clinical psychologists are. Being part of the Better Access system, this is a routine part of treatment.

Medicare classes a large number of other Psychologists as 'Generalist' it is evident that a large proportion of them have post graduate training relevant to mental health service provision. In my situation post graduate training in Applied Psychology and Abnormal Psychology has prepared me for the work I carry out in the general population. Ethically a registered psychologist is required to assess a new patient and determine if they are able to provide the appropriate treatment. If they feel that the needs for this patient are out of their realm of expertise, they refer them on. Perhaps to a Clinical Psychologist who specialises in a particular mental health disorder, or other psychologists who have worked in areas of mental health that have given them the experience and specialty training.

2. That the clients seen by clinical psychologists have more complex, chronic, and severe mental health disorders.

Every piece of research conducted on the Better Access scheme shows this to be false - there is no difference in the seriousness/difficulty-level of cases seen. In each study, over 80% of cases indicate moderate to high levels of symptom severity at the outset, with the same proportions of co-morbidity and so on. References below:

Giese, J., Littlefield, L., & Mathews, R. (2008, June). Survey of Members Providing Medicare-funded Services under the Better Access Initiative. *InPsych: The Bulletin of the Australian Psychological Society*, 30(3), 36-37.

Department of Health and Ageing. (2011). Evaluation of the Better Access to Psychiatrists,

Psychologists and GPs through the Medicare Benefits Schedule initiative. Retrieved from <http://www.health.gov.au/internet/main/publishing.nsf/Content/mentalbaeval>

3. That implication that clinical psychologists attain superior outcomes.

Again, there is absolutely no data at all to support this baseless claim. The studies cited above show otherwise, so in fact, we have data that contradicts this claim to superior outcomes. Then there are over 60 years of process-outcome research in psychology showing that the adjectival title of a psychologist or their training background has little bearing on their effectiveness as a therapist. Treatment outcomes are more about whether there is a good match between the presenting issues of the client and the characteristics of the therapist they choose to see for that presenting problem. This only emphasises the need for clients and their referring GPs to have a flexible choice of mental health practitioner to select from in the local community, so that a good match can be found.

4. That having a single-tiered rebate system will put us out of step with the western world (e.g., UK and the US)

This claim is based on many outdated (over a decade) documents. Therefore this is a baseless claim and is not evidence based. These claims are misrepresented as noted that one of the documents they claim to use as evidence for the two tier system states that only clinical psychologists were considered as they were comparing clinical psychologists with other professional groups, like social workers and occupational therapists etc.

It is important to note that the reality of the situation in the UK is that clinical and counselling psychologists both have equal status as specialist mental health providers, with both having the status of 'Chartered Psychologists'. In the US we have a similar more privatised system, where insurance companies do not distinguish between clinical and counselling psychologists. So it seems that removing the higher rebate for clinical psychologists and setting an equitable rebate for every mental health practitioner is not only much more fair on consumers, but it will also bring Australia more into line with the rest of the world!

The argument to discount the bias claims made by Clinical Psychologists to maintain the two tier system of rebates has been presented and I urge you to consider the points made.

In support of removing the two tier system, firstly and foremost it can be about cost cutting. If this is the main objective for the reduction in the required number of sessions (that is supported by research evidence), then I would applaud this method of reducing costs and therefore retaining the sessions for those patients who are in need.

Costs are inflated to the taxpayer when there are unnecessary differential rebates to Clinical Psychologists compared to all other Psychologists who provide an enormously beneficial specialised service to their patients.

Non ‘Clinical Psychologists’ should not be seen as being ‘less trained’ than Clinical Psychologists, many of us have trained in many areas and developed appropriate specialties that have provided us with the level of expertise that we demonstrate daily in our work. The amount of post graduate training that most psychologists undertake continually supports the basis of their being not lesser than Clinical Psychologist, purely they have chosen different paths.

Thank you for the opportunity to present my point of view, I urge you to reconsider the degrading of the level of Psychological services that are now provided under the Better Access Program, reducing the number of visits will harm those most vulnerable .

Sincerely,

Psychologist.