25 July 2011

Senate Community Affairs Reference Committee
Parliament of Australia

Re:- Senate Community Affairs Reference Committee Inquiry into Commonwealth Funding and Administration of Mental Health Services

**As a clinical psychologist caring for severely disturbed patients,
I respectfully request that my name and contact details be withheld from publication.**

Dear Senators,

Please accept my submission to the Inquiry of Commonwealth Funding and Administration of Mental Health Services.

I am a clinical psychologist and practise in both the public and private/primary care sectors. My public practice is within a specialist Early Psychosis Service and my private practice involves contracting within a general medical practice and seeing a range of adult patients with mixed diagnoses, but including many severe disorders. I initially trained under the 4+2 qualification framework as a registered psychologist and worked as a case manager in a public mental health service from 2002. I completed the supervised practice program in 2 years, gaining unconditional registration, and then continued to work in this field for 2 further years. However, I found that my education and skills were inadequate to effectively assess and treat the patients with whom I was charged. As an ethical professional, I decided that I would attain competence to practice in mental illness by returning to university to specialise. I enrolled in a Master of Clinical Psychology, and then articulated to the Doctor of Psychology (Clinical) program. My specialties include various psychotherapy approaches to treating schizophrenia and bipolar disorder, and a range of other disorders including severe anxiety and depression and personality disorders. I am successfully treating these patients and considered a leader by my peers, I supervise and teach post-graduate clinical psychology students, and consult to medical and other professionals on the psychology of psychosis, and participate in clinical research. Please consider my submission on the following topics

Rationalisation of the allied health treatment sessions and, 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

The term *rationalisation* does not do justice to the planned reduction of Better Access sessions from 18 to 10 per year. This is a blatant cost saving/shifting measure and the government needs to be honest with the community they serve. Genuine rationalisation would represent a simplification of the process that impedes patient access to the system, such as removing the requirement for a review by a General Practitioner after only 6 sessions, since when no research supports this.

With regard to severity of mental illness, my experience is that it is rare for a patient to present to a psychologist with a *mild* mental illness. The independent review of Better Access and the APS survey confirm that the severity of illness presenting to psychologists is in the severe range. Typically, patients with mild mental illness suffer in silence for many years until their difficulties become so severe as to impede coping in their daily lives, or lead to physical illnesses that bring them into

contact with their General Practitioner. The substantial investment of public monies into Better Access has gone into successful treatment of patients with severe mental illnesses. The government is correct to improve targeting of Better Access to members of the community with mild mental illness, however this would be better done by advertising the availability of Better Access and lowering the threshold to access by allowing all registered health practitioners, nurses, teachers and social workers to refer patients to a clinical or educational/developmental psychologist for an assessment in the first instance. That psychologist might then report back to the General Practitioner upon detecting a mental illness supported with psychometric measures. Prevention is one of the pillars of the National Mental Health Plan and should be a key target of Better Access. However, I have yet to see Better Access advertised and encouraged among the general population.

A *mild* mental illness does not automatically mean that it requires less sessions to treat. Mild in this sense means that fewer symptoms on the depression checklist are met, yet this illness can be highly disruptive to a patient's life, their occupation and earning capacity, and their family. Like severe mental illnesses, mild mental illnesses carry similar co-morbidities in physical health (e.g., alcohol abuse & obesity) with negative consequences for the individual and the community. Dysthymic Disorder for example, takes many years to develop and is a milder but more persistent variant of depression. This illness takes many years to develop and often takes substantial and persistent intervention over an extended period to correct.

The extended period of development of mental illnesses, often from childhood, and often after years of suffering, means that they tend towards a chronic course. Patients develop cognitive and behavioural schemas over decades that are resistant to change and prone relapse (i.e. old patterns die hard). Frequently, following successful treatment of any mental illness, a patient will have residual symptoms and require infrequent maintenance therapy for an extended period to prevent relapse. Without the rapid re-institution of therapy and the change process a patient may slip backwards, and even transition to more severe illness and disability. For example, early termination of treatment for agoraphobia (e.g., after 10 sessions) could worsen the original illness by suddenly withdrawing support too early. This risks further injury to self-esteem and confidence, major depression, and increases the risk of suicide, drug and alcohol use, and morbidity. Reducing access to 10 session means that many patients will effectively be half-treated and prone to relapse, effectively wasting the taxpayers investment and the patient's and psychologist's time, and risking a worsening of the patient's illness condition. Most reviews of the literature suggest that 20 sessions of psychotherapy is standard.

Many patients do not want to take psychiatric medication and are keen to eliminated their reliance on these chemicals. As ethical practitioners, we work with the patient and their General Practitioner to achieve their goals. The literature supports this end and this goal benefits the whole community. However, reducing medication is generally considered appropriate at the end of psychotherapy after the patient has developed alternative coping responses and has reduced symptoms. Limited psychotherapy to only 10 sessions will interfere with this process and further extend the burden to the community through PBS.

The reality of clinical psychology is that most of my work is with those at the severe end of the spectrum of mental illness, sometimes with those who have failed at therapy with less qualified and less experienced practitioners. These patients are those who may be receiving insufficient or no clinical psychological service from a public mental health service, since these services see only the most severe patients and typically employ junior non-clinical registered psychologists in *generic* case management roles who can provide little psychotherapy. I frequently take referrals of public mental health patients who require more help than the public system can provide, and bulk-bill these patients. One result of the government's proposed changes will be that the already overwhelmed public system will have to cope with these patients after 10 sessions. Yet, public system psychologists are often the most junior and non-specialists, and less able to provide the psychological care required.

I could not imagine the PBS limiting General Practitioners to only 10 prescriptions of antidepressants, based on a mild to moderate mental illness, and contrary to research findings. Yet, psychotherapy is

shown to be more effective and efficient in high prevalence disorders than medication. The government proposes that these patients will be better cared for under ATAPS, however I challenge this logic below.

The impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program

The government's suggestion that patients will be better served within ATAPS in incorrect. The management of ATAPS is unwieldy and a proportion of the funding for patient care will be spent on an administration that does not exist under Better Access. Better Access is more efficient than either public mental health or ATAPS. As an example, I see twice the number of patients in private practice that I see in public practice in the same timeframe, simply because of efficiency savings, and I work more closely with GPs. Better Access is more efficient than ATAPS because the patient is funded directly and the patient chooses their psychologist without the prolonged referral process.

ATAPS psychologists tend to be younger and less experienced, or less qualified because the Divisions and now Medicare Locals contract at a price that is accepted by these psychologists. As a clinical psychologist, I do not take patients from ATAPS because of the poor funding and have no intention of participating in this second rate system. I receive referrals direct from GPs and from mental health services/psychiatrists based on reputation, experience and qualification. Moving severely mentally ill patients under ATAPS will result in care by the most junior or least qualified psychologists and counsellors, while I will continue to see the less severe and privately funded patients for 10 sessions (actually I would rarely see less unwell patients for this long anyway). I anticipate that I will see fewer severely ill patients, those I am specifically trained to treat. This seems to be the opposite of the intention of Better Access and is a waste of the additional training that I have undertaken and of the community resource of Clinical Psychology.

Services available for people with severe mental illness and the coordination of those services

Patients with severe mental illness are unlikely to be effectively treated in 10 sessions, and will be unlikely to be treated effectively within ATAPS due to the junior or less well trained psychologists contracted under this system. They will be more likely to relapse and increase the burden on the already over-stretched public mental health system, where they will be less likely to receive effective clinical psychological interventions due to the predominance of non-clinical psychologists there in case management roles. For example, within my specialty, there are few psychologists, either within ATAPS or public mental health, skilled in the psychological treatment of the active symptoms of schizophrenia and bipolar disorder. The options for these patients is then reduced to medication that may be helpful in the short-term, but carry dire health risks in the long term, and general case management by psychologists with some 'therapy on the side' for comorbid anxiety and depression. Cognitive Behaviour Therapy for Psychosis is internationally recognised best practice but will become less available under these changes. It is yet to be seen how the proposed changes will improve coordination, but one simple initiative to do so would be to provide a Medicare item for clinical psychologists to case conference with GPs (GPs have an item for this!).

Mental health workforce issues and the two-tiered Medicare rebate system for psychologists

Within our profession, non-clinical psychologist are generally opposed to the 2 tiers and clinical psychologists are supportive of it. This is unsurprising, and I see both sides of the debate having been on both sides. The argument supporting a higher rebate for clinical psychologists relates to their specialist training in mental illness. In no other western country can a person be registered as a psychologist with only 4 years of university training, and without having ever laid eyes on a mentally ill

person. It is possible, and highly likely, that registered psychologists in Australia are seeing mentally unwell patients without specific training in mental health and illness. This is very concerning since the movement of the more severe patients into ATAPS, under the governments propositions, may expose more of these patients to less trained psychologists. Clinical psychologists undertake a minimum of 6 years (some 7 or more) university training including that specific to mental illness, including closely supervised placements in mental health, and then a registrar program. Registered and Clinical Psychologists are not equivalent in relation to practice in mental illness and remunerating at the same level would be another disincentive to practice within this system.

Clinical Psychologists invest effectively twice as much money and time in their training program compared to registered psychologists, and Clinical Psychologists sacrifice an additional 2-3 years of unpaid work to undertake this training. The 2 tier system recognises this specialisation with a financial premium and incentive. Without this incentive, it is likely that the demand for post-graduate clinical training will decline and with it the standard of care offered to the community. This is the reverse of the intention of the Psychology Board of Australia to raise standards to those comparable internationally. It would be better for standards of care to cease approving provider numbers to new registered psychologists and to phase-out tier 1 over time, and to require registered psychologists to contract under ATAPS under the supervision of a Clinical Psychologist. This would maintain the status quo among the psychology labour force in the short-term, while increasing incentive to extend training and improve service provision in mental illness in the long-term. Clinical Psychologists should given increased access to sessions under Better Access with reduced reporting requirements, since this is our field of specialty. Additionally, tier 2 rebates should be considered for the other psychology specialties requiring Masters and Doctoral level training, these are Educational/Developmental psychology, Clinical Neuropsychology, and Health Psychology.

Finally, it is acknowledged that there are many disadvantaged groups receiving inadequate psychological care. Additional incentives should be considered for service provision to disadvantaged groups and for practicing in rural or remote locations or by online facilities. At present, it is not financially viable to do so. I would consider relocating to a rural area if I were given an incentive similar to General Practitioners, and I would undertake telehealth consultations if rebates and facilities for this were available. Removing tier 2 rebates for clinical psychology will make these propositions less attractive, if not impossible.

The Senate has an important role in this inquiry in determining the future of mental health care for all Australians. This task is considerably more important than saving money by re-directing some to an inefficient and second-rate scheme that will contract lesser trained practitioners. I am grateful for the Senate considering my submission.