

## **Commonwealth Funding and Administration of Mental Health Services**

### **Submission from Dr Vanessa Spiller**

**I wish to address the following points:**

- 1. Changes to the number of Medicare rebated sessions from 18 to 10 per year**
- 2. Changes to the two-tiered funding for psychologists and clinical psychologists**

**In regards to point 1, I submit the following:**

I am a clinical psychologist in private practice in Stones Corner, Qld. Approximately 60% of my clients are concession card holders and are bulk billed due to economic disadvantage. Many have multiple mental health diagnosis and are not only financially disadvantaged but are also socially disadvantaged. Reducing the number of psychology sessions available to these clients from the current 18 sessions to 10 will have a severe negative impact on them but also on the public mental health system.

For example, one of my clients is a young man of European heritage - he was severely traumatized in his early adolescence and witnessed death, torture, starvation, and was separated from his whole family at 12 years old. After coming to Australia via NZ as a legal refugee, his mother died and he struggled to learn English. He now lives alone and has post traumatic stress disorder and severe social phobia. He has nightmares daily and has physical health conditions related to his enduring high levels of stress. What little money he has left over from his disability pension he spends on phone cards so that he can contact his surviving family members who live overseas. He has had 9 sessions of therapy with me so far this year however this is only just touching the surface of his many issues.

I am at a complete loss as to how anybody could receive sufficient treatment for issues such as these in 10 sessions. This equates to less than 1 session per month for the year. It doesn't allow for adequate rapport and safety to be established. It doesn't allow for the development of coping strategies and education before he can even start to tell his story. It doesn't allow for the additional sessions crucial to keep clients such as this out of acute mental health if they become suicidal.

Unfortunately, this client isn't atypical and I could tell you the stories of another six or seven clients whose lives are just as difficult in other ways, particularly those who have co-morbid mental health and substance abuse/misuse issues. However, they all share some common factors - complex mental health issues, financial and social disadvantage. All are on a pension or unemployment benefits and have no capacity to pay for counselling. Without access to private psychology services most would not receive any services except through acute public mental health which is already under-resourced and over-accessed.

The clients who require more than 12 sessions per year are in the minority in my caseload however the services they require are very important to their wellbeing and in my opinion minimise unnecessary hospitalisations. Funding additional psychology sessions for these clients would still represent significant savings in comparison to the provision of acute mental health admissions and

services. I would suggest that this small minority of clients would be better serviced by unlimited medicare rebated psychology sessions similar to that currently provided by psychiatry services.

**In regards to point 2, I submit the following:**

I am in favour of retaining the two levels of medicare rebates for provision of psychology services. The fundamental difference between clinical psychologists and generalist psychologists is that as a clinical psychologist and as someone who has also completed a PhD, I have additional specialist training **and have completed a multi-faceted assessment component that has determined that I am competent and proficient in the provision of these specialist services.** Many generalist psychologists have undertaken extensive professional development and training however very few training and professional development programmes include any standardised components of assessment or even assessment in any form. Thus it is possible to gain valuable knowledge from these programs however there is no standardisation of the specialist information that psychologists gain nor any assessment of an individual's ability to apply it. In this way, Clinical Psychologists are similar to Psychiatrists who also have to go through an accredited training program and have to demonstrate their competency and proficiency in recognised learning areas. They are suitably remunerated for their extra training and expertise.

In regards to the assertion that generalist psychologists achieve better or equal outcomes to clinical psychologist I would suggest the following. In my practice I personally measure the outcomes of the services I provide using an online version of the Outcome Rating Scale (ORS) and Session Rating Scale (SRS). These are well-established, cost-effective, time-efficient questionnaires that are both valid and reliable. They provide an accurate measure of client's levels symptomology and distress. There are currently over 10,000 registered users of these measures. There are many evaluations of these outcome measures which demonstrate that they have benefits to clients. The following is an excerpt from the publishers of these measures from their website:

Barry Duncan, Psy.D. & Scott Miller, Ph.D. Institute for the Study of Therapeutic Change  
954.721.2981; [www.talkingcure.com](http://www.talkingcure.com)

### Client Directed Outcome Informed (CDOI) Clinical Work

CDOI service contains no fixed techniques and no causal theory regarding the concerns that bring people to therapy or substance abuse treatment. Any interaction with a client can be client-directed and outcome-informed when the consumer's voice is privileged, recovery is expected, and helpers purposefully form strong partnerships with clients: (1) to enhance the factors across theories that account for successful outcome; (2) to use the client's ideas and preferences (theory of change) to guide choice of technique and model; and (3) to inform the work with reliable and valid measures of the consumer's experience of the alliance and outcome.

#### Why CDOI Service Delivery Is A Good Idea

- There is a growing worldwide movement, both private and governmental, to involve consumers in mental health and substance abuse care and improve the outcome or value of rendered services. CDOI delivery systems partner with consumers in all aspects of care and are a natural fit for this paradigm shift.
- The use of evidence based practices (EBP) does not guarantee success. In recognition of the inability of any model to predict success for the individual client, the APA Task Force on EBP suggested that "*ongoing monitoring of patient progress and adjustment of treatment as*

*needed are essential.*” CDOI provides a method to combine EBP with “practice-based evidence” to ensure success at the individual client level.

- A small percentage (about 10%) of the total number of people treated—unsuccessful clients—accounts for 60-70% of expenditures. Drop out rates average 47%. Making matters worse is the fact that clinicians often fail to identify clients at risk for dropping out or unsuccessful outcome. CDOI provides an early warning system to identify failing clients based on the best known predictors of outcome and retention.
- Two factors are strongly predictive of retention, progress, and the eventual success of treatment: The consumer’s rating of the alliance with the provider of services and the consumer’s rating of early progress in response to the provider, level, and type of treatment offered. CDOI monitors these two predictive variables with reliable, valid, and feasible outcome and alliance measures.
- Providing clinicians with ongoing consumer feedback regarding the alliance and progress in treatment dramatically increases success rates for at risk client (65% on average) as well as the cost-effectiveness (reduces cancellations, no shows, length of stay, etc) of provided services.

#### From Research to Practice: Current Applications and Results

- **The Center for Family Services (CFS)** of Palm Beach County, FL: Using CDOI since 2001 w/ children & families, diverse populations— In December 2006, in collaboration with the Community Partnership Group, awarded a 1.2 million dollar grant from the State of Florida’s Department of Children and Families Substance Abuse and Mental Health Office for a 3 year pilot using CDOI services with adults diagnosed as having co-occurring disorders
- CFS conducted the first systematic analysis of “efficiency” after implementation of CDOI practice, and compared the average number of sessions, cancellations, no shows, and % of long-term cases before and after CDOI practice implementation on a sample of 2130 closed cases seen in a public CMHC (this study is reported in a peer-reviewed publication: Miller S., Duncan, B., Sorrell, R., & Brown, J. (2005). The Partners for Change Outcome Management System. *Journal of Clinical Psychology: In Session*, 61, 199-208).
- Average number of sessions dropped 40% (10 to 6) while outcomes improved by 7%; cancellation and no show rates were reduced by 40% and 25%; and % of long term null cases diminished by 80% (10% to 2%). Resulted in an estimated savings of \$489,600; such cost savings did not come at the expense of client satisfaction with services—during the same period satisfaction rates improved significantly.
- **Southwest Behavioral Health**, Phoenix, AZ: Using CDOI since 2003 with broad range of clients—State of Arizona noted CDOI services as a “Best Practice,” and implemented it in its Methamphetamine Centers of Excellence Program with plans for statewide implementation. The analysis comparing before and after implementation will be published in the forthcoming second edition of the American Psychological Association’s best selling *Heart and Soul of Change* (Duncan, B., Miller, S. & Wampold, B., in press).
- Improved Perfect Attendance in Addiction Services from 22% to 69%; Improved Perfect Attendance in Co Occurring “Disorder” Program from 27% to 70%; Reduced length of stay across programs by 50%
- **Resources for Living**, Austin, TX. Using CDOI since 2000 with telephonic Employee Assistance Program clients. First use of automated feedback system resulted in significant increase in agency effect size as well as client retention. Based on over 6,000 clients, success rates improved by 65% over previous baseline levels (reported in a peer-reviewed publication: Miller S., Duncan, B., Brown, J, Sorrell, R., & Chalk, M. (2007). Using formal client feedback to improve outcome and retention. *Journal of Brief Therapy*, 5, 19-28).
- **The Center for Alcohol and Drug Treatment**, Duluth, MN: Using CDOI services since 1997 with substance abusers—attained the State’s best retention percentages, improving from a 50% completion rate to an 82% completion rate The analysis comparing before and after implementation will be published in the forthcoming second edition of the American

Psychological Association's best selling *Heart and Soul of Change* (Duncan, B., Miller, S. & Wampold, B., in press).

- **Community Health & Counseling Services**, Bangor, ME: Using CDOI services since 2003 with clients diagnosed with severe mental illnesses—dramatically improved retention and efficiency of services with perhaps the most difficult to serve clients. The analysis comparing before and after implementation will be published in the forthcoming second edition of the American Psychological Association's best selling *Heart and Soul of Change* (Duncan, B., Miller, S. & Wampold, B., in press).
- The length of stay was reduced by 72% in case management services, 59% in psychotherapy services, and 47% in residential treatment
- The number of no shows and cancellations has reduced by 30%; Satisfaction with rendered services has improved while complaints have reduced resulting in a decrease in liability.
- **The Center for Child & Adolescent Mental Health and the Family Counseling Offices**, Norway: Using CDOI since 2002 in a national mental health care system in compliance with government initiative to include consumers in treatment decisions—currently running pilot to determine further implementation. Also in Norway, a large study investigating the use of client feedback in couple therapy is nearing completion (Anker, M., & Duncan, B. in preparation). With data collected now from over 600 clients, the incorporation of client feedback into therapy reduced the risk of a negative outcome by over 50%. As soon as the study is complete, it will be submitted for publication.
- **There are now over 10,000 registered users of the progress and alliance measures—the Outcome Rating Scale (ORS) and Session Rating Scale (SRS)—and data collected on over 300,000 administrations.**

Source: [https://www.myoutcomes.com/documents/CDOI\\_Facts.pdf](https://www.myoutcomes.com/documents/CDOI_Facts.pdf)

As a user of this on-line measure of therapist effectiveness I can confidently state that I have above-average outcomes for the client who I provide a service for. I can say this because the outcomes I achieve can be compared with the database of outcomes for 10000 other registered users. I have a corrected effect size which is almost 1 standard deviation above the average change experienced. I have met very few psychologist generalist or clinical who measure there outcomes. I believe that the widespread use of standardised outcome measures are required to provide better, more cost-effective services to the community. Until outcome measurement is regularly incorporated into the practice of every psychologist, it is not possible to determine which psychologists are more effective than any others.

I thank you for receiving my submission.

Regards,

Vanessa Spiller (MAPS)

BA(Psych)(Hons); MPsych(Clin); PhD