SYDNEY CLINICAL PSYCHOLOGY

28 July 2011

I wish to provide a submission on the following issues that are being reviewed by the senate inquiry.

Background

I am a Clinical Psychologist of ten years standing. I have spent most of my career as a clinical psychologist working in the public hospital system at Royal Prince Alfred Hospital. During this time I specialised in working with people with people with chronic illness. I managed a multidisciplinary team, developed and ran a service for people with chronic pain, and presented our innovative service and impressive outcome data and international and local conferences.

I am an Associate Lecturer in the School of Psychology at the University of New South Wales, where I teach in the Masters of Clinical Psychology programme. In my roll at RPA I regularly supervised intern clinical psychologists, and currently provide professional supervision to a number of qualified clinical psychologists.

In the last twelve months I have transitioned to fulltime private practice in the Inner West of Sydney, close to the hospital and the University of Sydney. My practice bulk bills approximately forty percent of our clients, many of whom are students, unemployed, or people with chronic problems. We specialise in the treatment of self-harm, anger, personality disorders, chronic pain and postnatal depression. We also specialise in the interaction between health problems, such as obesity and diabetes, and mental health problems.

Approximately fifty percent of the people seen in my practice would be classified as having moderate to severe psychological problems, according to the Diagnostic and Statistical Manual of Psychiatric Disorders, Fourth Edition, Text Revision. Furthermore, I am as registered provider with the government's suicide prevention initiative, and, through my advanced training in Dialectical

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Behavioural Therapy, I regularly treat people with severe levels of self-harm, alcohol, and drug abuse. As such around fifteen percent of the people seen in my practice have mental health problems that are life threatening. Taken together this means that around thirty five percent of people I see would fall in the mild to moderate category.

(a) the Government's 2011-12 Budget changes relating to mental health

The Government has indicated that over $2 billion dollars will be allocated to mental health funding. Since then it has become clear that the allocation will be around $500 million over the next four years, and the allocation of money to psychological services will occur mainly through the ATAPS system. Of this $500 million, only $60 million will be available in the first of the four years.

It has also become clear that the additional funding allocated to psychological services will largely be distributed through Medicare Locals. This means that geographical areas not represented by a Medicare Local will receive a net fall in funding with the proposed restrictions to Better Access. With only one Medicare Local currently approved in the Sydney area, this will lead to an immediate Sydney wide fall in services available.

A further point to note is that some divisions of general practice, such as the division that covers much for the northern Sydney area, do not offer ATAPS at all. As a result individuals in these areas will be greatly harmed by this proposed change, both now and in the long term.

Finally, the proposed figures quoted, and the increased emphasis on ATAPS, misleads the public on the issue of the scope of access to psychological services. The figures suggest significant investment in mental health, and while the figures are substantial, the net effect on the ground is minimal. By way of an example, Central Sydney GP Network covers some 800,000 people of varied cultural and socio-demographic backgrounds in a diversity of areas such as Lakemba, Canterbury, Newtown, and Strathfield. With the increased level of funding it is receiving, this division of general practice will be able to provide sixty ATAPS referrals a month in 2011-2012 (written communication from Central Sydney GP Network to their ATAPS providers dated 02 July 2011). That is, two referrals a day to cover 800,000 people.

Recommendations

The division of funding using ATAPS is inequitable as it allocates funding based on the allocation of Medicare Local status, and whether a division of general

practice wishes to offer ATAPS. While there may be a long term vision for this model, it is simply the case that, for the next four or five years at least, this model will grossly under service those with mental illness. An alternative model involves the continued provision of services under the Better Access scheme. This model has been on of the most successful public health programmes in many years, and with appropriate management it could continue to grow in it's scope of application and impact.

Better Access has been criticised because of the locations in which services are delivered. However, these locations simply reflect the locations of the universities that train psychologists. In New South Wales three of five major psychology training universities are located close the centre of Sydney. As such, by the end of an undergraduate degree the majority of psychologists trained in New South Wales would have lived in the inner Sydney suburbs for four years, and by the end of a postgraduate degree almost all clinical psychologists will have lived in this area for six or seven years. As such it is no surprise that these people choose to find work locally.

There is, therefore, a need to provide incentives to privately practicing psychologists to set up practices elsewhere. One way to do so is to encourage NGO's and private practices to set up networks in these currently underserviced areas. Organisations in other fields are often incentivised in similar ways to set up in certain areas. Once this set-up occurs local professional networks would emerge that pull together mental health professionals. This has recently been demonstrated by the success of the Mental Health Practitioners Network. Such networks are also common within government agencies, such as DADHC. Furthermore, An organisation that ran several offices in different geographical areas could provide the infrastructure and support mechanisms to sustain further investment in more diverse areas.

(ii) the rationalisation of allied health treatment sessions

The decision to rationalise treatment sessions was based Medicare data about the general public's access to these services. This decision goes against principles of evidence based practice. Experts in data analysis organise statistical techniques in a hierarchy from the most reliable to the least reliable. The statistical approaches used in the Better Access analysis were appropriate for a field study, but would be considered far less robust that those used in randomized controlled trials. Thus, robustly designed clinical trials indicate that twelve to sixteen sessions is necessary to treat many psychological conditions, and yet the government has chosen to make a decision to reduce funding to ten sessions based on Medicare data that is collected using less reliable methodologies.

it is clearly misleading to use simple averages for service planning, which should be driven by more robust scientific data. While it may be the case that the Better Access evaluation indicates that the average number of people are helped in a small number of sessions, this data is skewed by the large number of people who only need simple support and advice and therefore need very few sessions, those who drop out of treatment without completion, and people who change therapists, all of which would artificially deflate the average number of sessions. It is quite likely that this group may constitute twenty to twenty-five percent of people accessing services under Better Access.

What is more a concern, however, is that a change based on this data treats as irrelevant the smaller group of people who need more than the proposed ten sessions, which is mainly the people who access eighteen sessions under the exceptional circumstances provisions. These people are likely to be from the more severe end of mental illness and represent, by the government's own data, approximately 15% of all people who accessed Better Access.

The change from eighteen to ten sessions may seem relatively small on face value. However, eighteen sessions provided fortnightly, when annual leave and sickness are factored in, can provide close to one year's treatment for someone with severe mental illness. This means that people requiring longer term treatment can obtain it across several years without a significant break in treatment. The evidence clearly supports the view that those with more severe illness require longer term treatment, both in terms of duration and number of sessions. Indeed, a number of researchers of international standing have suggested that moderate to severe depression requires an average of eighteen sessions of treatment. While Better Access only provides for eighteen sessions a year, careful planning allows for a longer term treatment plan across several years, which is more aligned with the evidence for treatment of more severe problems, such as borderline personality disorder.

According to the federal government, people with more severe illness will now be able to access the public system, private psychiatrists, and psychology services under ATAPS. This shows a very poor understanding of the available services.

The public mental health system remains over-burdened with long waitlists. By way of an example, in the area of Central Sydney GP Network, which services over 800,000 people, there is one anxiety clinic at Bankstown, no specific service for depression, and one small service for eating disorders. There are a number of community mental health centres that are overloaded and are very restricted about who they will accept for treatment. There is one Dialectical Behavioural Therapy programme at RPA hospital, which treats people with borderline personality disorder, and has sixteen places available at anyone time. This service has a nine month waitlist.

Private psychiatrists within this highly populated area, close to the city, and containing many people from higher socio-demographic groups, are usually booked out for months at a time. I am rarely able to find a private psychiatrist who will see one of my clients at less than a month's notice. Almost all charge a large gap fee ($100-$150 is common), very few of bulk bill, and very few of offer an alternative to psychopharmacotherapy. And yet this group will continue to be allowed to provide up to 50 sessions a year under Medicare, while psychological services, which are clearly less expensive and more widely available, are being cut back.

The ATAPS scheme is grossly under-funded despite government claims to the contrary. As already noted, Central Sydney GP Network will offer funding for 60 ATAPS referrals a month for 2011-2012. A referral, however, is for six sessions. If, as the government claim, this scheme is aimed at the more unwell who will need more than six sessions, it is clearly case that much less than 60 people a month will be able to access ATAPS in this area.

Recommendations

Psychologists and Clinical Psychologists are well positioned to provide a broad range of private sector services. The design and implementation of services should be based on evidence based practice, rather than epidemiological data. Treatment providers should be evaluated against their capacity to deliver evidence based treatment. This could easily be measured and managed by a panel of experts who undertake ether (a) random audits; or (b) audits amongst treatment providers whose service provision raises concerns.

Later in this submission the differences between generalist and specialist clinical

psychologists will be addressed in more details. The reader is referred to this section. On this basis it is recommended that Clinical Psychologists provide services to those with moderate and severe mental illness, and that the provision of services to those with mild to moderate severity of problems be open to generalist and clinical psychologist.

(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

The current MBS schedule includes items for Focused Psychological Strategies, provided by allied health professionals including registered psychologists, and Specialist Clinical Psychology Services, provided by clinical psychologists.

Clinical Psychologists receive post-graduate training in the assessment and treatment of psychological disorders. They are trained to treat people with disorders ranging from mild to severe. Clinical Psychologists will be restricted in their capacity to provide treatment for people with moderate to severe problems under the changes. It should be noted that previously under Better Access the clinical psychology items were aimed at people with moderate to severe problems, and the data suggests that they have received effective treatment.

In my practice limiting services to those with mild to moderate conditions would mean that we would not seen two thirds of the patients we currently see, many of whom are bulk-billed or pay a small gap. Importantly, this would also mean that I would not be providing my service to people with life threatening psychological problems. Given the huge shortage of services for this group, this would directly endanger the lives of Australians.

Clinical Psychologists are the only psychologists with a postgraduate degree level of training in the treatment of psychological disorders. I would argue that Clinical Psychologists have equivalent, if not better training, to treat these people than psychiatrists, and therefore I question the inequity of psychiatrists being able to deliver fifty sessions while Clinical Psychologists will only be able to deliver ten.

Recommendations

Clinical psychologists are trained in the provision of mental health services to people of varying severity. By restricting privately practicing clinical psychologists to the treatment of mild to moderate problems under Medicare, their skills are being grossly under-utilised. This occurs in the context of a serious shortage of affordable private psychiatric services.

It is recommended that clinical psychology services be retained for the provisions of services to people with moderate to severe mental illness, and be expanded to allow clinical psychologists to provide a greater range of services. This expansion should lead to a lower overall cost due to the shift from psychiatric to psychological services, as psychological services are more widely available and less costly.

One possible model would be for the general practitioner to refer to the clinical psychologist for assessment and treatment. The clinical psychologist could provide the treatment plan to the general practitioner. This would save the current doubling up in which the general practitioner completes a mental health care plan, then the clinical conducts one to two assessment sessions as per their professional standards and training.

A further model would involve the option of a person being able to receive both Focused Psychological Services and Specialist Clinical Psychology Services in the same year. Under this model a person meeting certain criteria would first be referred for FPS. Following a brief intervention using the FPS progress would be reviewed. At this stage the provider would either provide a few extra sessions, terminate treatment, or refer on. A referral for Specialist Clinical Psychology Services would occur under one of two conditions. First, the person may be deemed sufficiently severe to require such a referral. Second, the person may have failed FPS and require a more specialized intervention. Under this model service costs would be lower as more people would receive FPS first, and those with greater needs could see a specialist who could provide more appropriate treatment.

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

As previously noted, in an area of 800,000 people, 60 ATAPS services a month will be delivered. This is clearly inadequate.

ATAPS provides for a very limited service delivery in many ways. This limitation impacts on members of the general public receiving appropriate treatment. For example, the Department of Health determines what treatments are appropriate under ATAPS. Last year they deemed Dialectical Behavioural Therapy as inappropriate. DBT has been shown in well designed randomized trials to be an effective treatment for borderline personality disorder, self-harm, eating disorders, domestic violence and substance abuse. The treatment is widely regarded across the globe as a gold standard treatment, and yet the Department of Health did not recognize this. Further, DBT, and indeed many other treatments, are best delivered in a group based environment, and yet the ATAPS scheme provides very little support for this modality.

The ATAPS scheme provides no mechanism for funding Family Therapy, Interpersonal Psychotherapy, Relationship Therapy, or Acceptance and Commitment Therapy, each of which has substantial evidence bases.

The ATAPS scheme provides a low fee for service, typically around $110 a session. The award hourly rate for a senior clinical psychologist approaches $50 per hour, plus benefits, such as superannuation, holiday pay etc, making the real employment rate closer to $60 an hour. It is generally accepted that clinical psychologist working in the 'public system' would spend about 50% of their week in client contact. Assuming an unrealistic 100% show up rate of clients, 52 weeks a year, with 50% of available time allocated to client contact, an employer would require $120 a session to break even on a psychologist employed to provide ATAPS services. While these figures are approximate they do demonstrate the lack of appeal ATAPS offers to potential employers of clinical psychologists.

These figures demonstrate why ATAPS services are often delivered by recent graduates or lower qualified registered psychologists. And yet the government claims that ATAPS is aimed the more severe mentally ill. Clearly there is a problem in encouraging lower qualified people and more recent graduates to treat the more severely unwell. This is also completely incongruent with the approach of other professions, such as the medical profession, which emphasise more experienced members of the profession treating the more complex cases, and shows a disregard and disrespect for the problem those with mental illness.

Recommendations

The current ATAPS programme is simply unable to provide for the number and diversity of people with mental health problems. The Better Access, scheme, on the other hand, can provide this, and as such ATAPS needs to be balance with the provisions of the Better Access scheme.

The APAPTS programme needs to be redesigned to balance the right type of professional with the level of service provided. Basic ATAPS services aimed at less severely unwell people could be provided under the current structure. However, people with more severe problems need to be treated by higher qualified professionals. This will only occur if ATAPS allows for greater flexibility in service provision, and a funding structure that is appealing to more senior and better qualified professionals.

(e) mental health workforce issues, including: (i) the two-tiered Medicare rebate system for psychologists,

The two tiered system reflects the differences in qualifications and skills between clinical psychologists and registered psychologists. Clinical psychologists have, at the minimum, a Masters level degree in clinical psychology, although many now hold professional doctoral degrees. A registered psychologist has undergone a two-year internship. Both have undertaken an undergraduate degree in psychology, which contains no clinical training whatsoever.

Clinical psychology postgraduate degrees are certified by the Australian Psychology Accreditation Council, and are conducted by psychology departments in the major universities. Intern clinical psychologists train under qualified clinical psychologists in institutions such as major teaching hospitals and community mental health settings. Until very recently registered psychologists engaged in a two year programme that involved a far less structured and regulated programme. Much of their training was self directed and occurred within the context of a learning plan. Education involved attending workshops and seminars. Although the subject matter of the workshops was stipulated in the learning plan, there was no control over the detailed content, and more importantly, who delivered the training.

It is noteworthy that, until recently, an individual could fail a Masters in Clinical Psychology and still fulfill the requirements to be a registered psychologist. Until recently a registered psychologist could also gain their registration working, for example, at the Department of Community Services as a caseworker delivering very limited counseling services, then upon gaining full registration set-up a private practice and treat any condition presenting to their service. While the training of registered psychologists has become more regulated in recent years, the vast majority of registered psychologists gained their registration this way. Furthermore, I am aware of psychologists being trained in a very limited model like this currently, who are about to start a broad-ranging private practice. This is clearly of grave concern.

The distinction between clinical psychologists and registered psychologists has come under criticism by registered psychologists unhappy that they cannot access a higher level of rebate under Medicare. However, this distinction has long been recognized the industrial relations tribunals across the country. All state awards make a distinction between the training and qualifications of these two groups. They also make explicit the types of work each should perform, and different pay scales for each group.

Internationally the standards are very different, and Australia has very low standards compared to other countries with advanced mental health care systems. In the USA and Canada the minimum certification for a practicing psychologist is a Doctoral degree, while in the UK it is a Masters degree, although the degree takes three years and not two as in Australia. Individuals without such qualifications are severely restricted in the type of work they are allowed to do, which is generally limited to an assistant's role. This higher level of training affords protection to the general public not available in Australia.

Recently a group of registered psychologists have argued that the recent Better Access evaluation proves unequivocally that there is no difference in service delivery between registered psychologists and clinical psychologists. This shows a very poor understanding of data interpretation and outcome studies psychology. Other submissions will not doubt examine this point in closer detail. As such I wish to simply state that the Better Access evaluation was an uncontrolled field study designed to address some very broad questions. A basic education in statistics is all that is required to understand that (i) data is almost never unequivocal, and never so in study with this type of design, and (ii) a meaningful difference between two groups cannot be established with such a design, and (iii) can only be established form a far more robust design. Such analysis skills are a core component of postgraduate clinical psychology courses.

Finally, it should be noted that the majority of large scale randomized controlled trials conducted to establish treatment efficacy and effectiveness are conducted in the UK and USA. As noted previously, only postgraduate qualified psychologists practice clinically in these countries. As such these trails are run by postgraduate trained clinical psychologists (and psychiatrists). This is also the case in Australia. The treatment in a trial is often conducted by intern clinical psychologists undergoing a postgraduate degree, who are supervised by qualified postgraduate degree qualified clinical psychologists. However, in the case of more advanced treatments, such as Dialectical Behavioural Therapy, the treatments are often run by qualified, postgraduate trained clinical psychologists. As such it is clear that the evidence supports the provision of psychotherapy by postgraduate qualified clinical psychologists, and that there is little current support for the view that such treatments can be delivered effectively by registered psychologists trained under the Australian system.

Recommendations

It is recommended that clinical psychologists, by recognition of their training and skills, continue to be deemed specialist providers of mental health services. This would be consistent with state and federal awards.

It is recommended that local standards be aligned with international standards, and that the government work towards a minimum standard of a postgraduate degree for a psychologist who practices clinically.

(ii) workforce qualifications and training of psychologists,

The international standard for training psychologists who work clinically is a postgraduate degree. This standard is endorsed by the Australian Psychology Accreditation Council. On its establishment the Psychology Board of Australia argued for a minimum requirement of a doctoral degree, with a grandfathering clause covering currently practicing psychologists who currently meet the criteria for clinical endorsement (the board's term for a clinical psychologist). However, this position was not accepted by the Australian government.

It seems clear that the standard for a clinically practicing psychologist in Australia should be a postgraduate degree, which would simply align local standards with international standards and the recommendations of local key stakeholders.

(iii) workforce shortages;

Currently postgraduate trained clinical psychologists represent just 20% of all registered psychologists. This imbalance occurred through many historical factors, such as the shortage of university courses and the cost of undertaking such a course. There have been attempts in recent years to address this issue, however, the number of postgraduate trained clinical psychologists will remain low while the number of university courses remains low.

The Australian Psychological Society admitted a large number of psychologists into the College of Clinical Psychologists following the advent of the two tiered Medicare system. This occurred through what were known as bridging plans. A number of senior clinical psychologists opposed this up-skilling of registered psychologists to meet the standard of a postgraduate trained clinical psychologist. However, this process recognised that non-clinical college psychologists, such as those without postgraduate degrees, may have gained experience and seniority in keeping with the title Clinical Psychologist. It also recognised the workforce shortage in clinical psychologists, and the need to unite the profession on the view that the term clinical psychologist conveyed specialist title. It is unfortunate that such a move ultimately led to division within the profession. It is noteworthy that several individuals who failed to gain membership of the clinical college through this route then formed a rival organisation whose aim now appears to be to discredit clinical psychologists.

Recommendations

I would suggest that a bridging plan system be reintroduced to open up clinical psychological specialisation to people with appropriate skills and training. This system should be administered by the Psychology Board of Australia. However, the bridging plan system should only be open for a limited period of time.

A more general approach would be to set up a rigid national examination system to gain clinical specialisation. This exam would, for a limited period of time, be open to anyone with appropriate work experience. Following this, the exam would then be open to anyone who completed an accredited training programme. This exam should be set to the standard required to pass a postgraduate degree in clinical psychology, and should be administered by the Psychology Board of Australia.