24 July 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**:**

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

2. The current Medicare rebate system for psychologists

1. **Changes to the number of allied mental health treatment services**

We would argue to maintain the current the number of sessions of psychological treatment a person with a mental health disorder can receive each year to a maximum of 12-18, rather than 10 as proposed. A recent evaluation of the Better Access initiative found that this service significantly improved psychological well-being and was so cost-effective that it surpassed positive predictions about the scheme by a wide margin. However, new investment in mental health care should not come at the cost of our existing services that are working well to improve the psychological wellbeing of Australian citizens.

The plan to cap psychological treatment at 10 sessions, falls below standard treatment protocol for the management of even the most uncomplicated psychological conditions. Recent research undertaken by the Australian Psychological Society (funded by the Department of Health and Ageing) shows that the average length of individual treatment for mental health disorders is 15-20 sessions. New research conducted by Harnett, O'Donovan and Lambert (2010) shows that for 85% of people to show clinically significant change in their level of symptom severity, around 20 sessions of treatment are required. This research shows that with 10 sessions of treatment, around half of people will need more psychological care to improve. These figures match survey data from the Australian Psychological Society about the work of psychologists in the *Better Access* scheme. Limiting the maximum length of treatment at 10 sessions is plainly unrealistic and will set many people up for failure in the system.

Along with many of my colleagues, I do not think it is fair to take such a tough stance on people who are already struggling with psychological distress. These new proposals apply pressure to both clients and the psychologists they consult with, to achieve results over a very brief period of contact. My concern is that this new policy will be frustrating for many people, who will simply give up. Psychologists are expected to select evidence-based treatments, but will only be able to do half of the job. This would be like going to a dentist for a check up and only getting half of your teeth looked at; or seeing a GP and only being given half a dose of antibiotics. The government has recently indicated that they have doubled the funding in certain areas of mental health. However the plan to cut therapy short after **just 10 sessions with a psychologist** will produce significantly poorer outcomes for what has been arguably the most successful mental health program in the last 30 years. Addressing 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.

In my role as a Clinical Psychologist I treat many moderate to severe psychiatric disorders, which most definitely cannot be treated successfully in 10 sessions. Therefore a reduction in the number of sessions available would only be a bandaid, and of no clinical or practical use with these populations. Many of my clients are also low income and billed at the bulk billing rate, and would not be able to continue with therapy once the Medicare rebate had cut out.

The Government has stated that people with serious mental health disorders who need more than 10 sessions of treatment should receive services through the specialised public mental health system, private psychiatrists or the expanded Access to Allied Psychological Services (ATAPS) program. There are concerns that people with severe depression, anxiety related disorders, and personality disorders will not be able to get into public mental health services, be able to get timely or affordable access to a psychiatrist or into ATAPS which we understand cannot accommodate all these people.

Policy-makers have argued that after 10 sessions, those who can prove they have a more serious mental health disorder will be able to access other programs. But this will require them to straddle several different schemes and may even mean they will have to start again with a new psychologist. People are going to slip through the cracks in this confusing new system and many people will simply give up. Being given an inadequate length of time for treatment at the beginning will set people up to fail. Further any requirement for people to prove how serious their mental health problem is will stigmatize those who reach out for help.

As the recent Better Access data indicates, only around 15% of clients used the 11-18 sessions, so in real terms this is not a major expenditure within the mental health budget. The original intention of the Better Access funding was to relieve the psychiatry budget, whereby patients would be seeing a psychiatrist for three times the rate as a clinical psychologist. In reducing the number of sessions many Clinical Psychologists would need to refer patients back to psychiatrists in the private health sector, which would triple the government's mental health budget expenditure. Overall this would prove to be counter-productive to the government's budget, and the patient's continuity of care.

2. The current Medicare rebate system for psychologists

The following arguments are put forward to reinforce the practical and clinical validity of the distinction between "Clinical Psychologists" and "Generalist Psychologists" with respect to Medicare Rebates.

1. Original Decision made by the Australian Government in 2006 to make a distinction between the rebates for Clinical Psychologists and Generalist Psychologists

The decision made by the Australian Government in 2006, to admit psychologists into the Medicare payment system and provide rebates for their services was a hugely important development in the effective treatment of Mental Illness in Australia. Mirroring the existing distinction made by Medicare between the services provided by General Practitioners and Specialists from the Medical Profession, the decision was made to distinguish between Generalist Psychologists and Clinical Psychologists. This was a carefully considered decision made after consultation with many providers in the health system and by making a systematic evaluation of which professionals are in the best position to provide treatment services to people with a serious mental illness. The decision recognized two important issues:

a) **That there is a significant and objective difference between Clinical Psychologists and Generalist Psychologists with respect to their education, training and experience in dealing with serious mental illness.**

b) That as a result of their specialized training and experience with serious mental illness, **Clinical Psychologists are better equipped to assess and treat the complex presentations** of people with serious mental illness. This complexity often involves co-morbid psychological problems such as personality disorders and drug and alcohol abuse – additional to a primary diagnosis, for example, of a Major Depressive Disorder, a Bipolar Disorder or Schizophrenia.

2. Recognition and support for the distinction between Clinical Psychologists and Generalist Psychologists by Australia Psychological Society.

The pre-eminent professional body representing practicing psychologists throughout Australia is the Australian Psychological Society (APS). The APS has 20,000 members and works hard to promote the professional role of Psychologists, both with respect to its members and also within the broader community. **The APS has stated its support for the distinction between Clinical Psychologists and Generalist Psychologists in the Medicare system.** It is a distinction which is also recognized in the US, the UK and in Canada where Clinical Psychology is a regulated Health Profession.

Clinical Psychologists recognized by the National Registration body for Psychologists in Australia (AHPRA) and by Medicare are required to be Members of the Clinical College of the APS or to have equivalent academic training and clinical experience that would make them eligible to be members of the Clinical College of the APS.

The current minimum academic requirement for entry to the Clinical College of the APS is a Masters degree in Clinical Psychology. With the necessary 4

year undergraduate study required for entry into a Masters degree and the two years study required for the Masters degree – making a total of 6 years of academic study. Applicants also require two years of approved clinical experience in the workplace, under the Supervision of a Clinical Psychologist, to obtain membership of the APS Clinical College.

There are very strict standards applied to the accreditation of Masters and Doctorate level courses of study in Clinical Psychology, which result in graduates having the most appropriate theoretical and practical training for assessing and treating serious mental illness. The following section taken from the APS Website (2011) summarizes the comprehensive goals of every accredited clinical psychology training program:

" In effect, the program must demonstrate that each student has performed satisfactorily on a set of core capabilities identified as essential for clinical psychology practice. These are:

(i) Capabilities for the assessment, diagnosis, and differential diagnoses for common psychological disorders across severity levels and the life span.
(ii) Counselling skills including the capability to form and maintain a therapeutic alliance with diverse clients across age ranges.
(iii) Knowledge of principles, procedures, and applications of AND competence in conducting an empirically based intervention for common psychological disorders across severity levels and the life span.
(iv) Knowledge and skills in case conceptualization for common psychological disorders across severity levels and the life span.
(v) Knowledge of professional, ethical, and legal issues and competent interpretation of these codes in clinical psychology practice
(vi) Meta competencies including effective reflective practice and the scientist-practitioner approach to clinical work. "

In contrast to the very specific academic training and work experience in the area of serious mental illness outlined above, which is a mandatory requirement for Clinical Psychologists to use the title “Clinical Psychologist” - there is an enormous diversity in the formal training and experience, with respect to the assessment and treatment of serious mental illness, among the group of psychologists registered as “Generalist Psychologists”.

In conclusion, I believe that the proposed cuts in the Better Access program are ill-advised; they would compromise Best Practice in the provision of Mental Health Services and would ultimately result in budget blowouts in other areas. Further, I strongly support the two tiered system of Medicare Rebates for psychologists as it stands – with the recognition of the difference in the skills of Clinical Psychologists. It is a distinction which is recognized world wide and is reflected in the training and practice of Clinical Psychologists.

3. Characteristics of my own training and practice as a Clinical Psychologist.

I have completed an undergraduate honours degree in psychology and a post-graduate Masters in Clinical Psychology. The entry to the Masters degree was a competitive process and I completed it over 4 years while working as a psychologist. Following the Masters degree and before commencing private practice I worked in the Public Mental Health sector as a Clinical Psychologist for 17 years. I am now the principal of a Clinical Psychology practice, which has 7 practitioners. All people in the community have access to our services as we offer bulk billing to low income earners, pensioners, health care card holders and youth.

Michele M. Colman

Clinical Psychologist

BA(Hons), MSc, MA (Clinical Psychology), MAPS (Clinical College)