

2nd August 2011

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Re: Commonwealth Funding and Administration of Mental Health Services

In accord with the Guidelines provided, we submit the following for your consideration. This submission focuses on the Government's 2011-12 Budget changes relating to mental health, specifically the potential impact of the proposed changes to the Better Access Initiative.

We the undersigned are specialist Clinical Psychologists with extensive skills and experience in provision of specialist mental health services in both public and private mental health treatment agencies. Together, we have over 60 years of experience in provision of services to people with complex and chronic problems. We are also engaged in the post graduate specialist professional training of clinical psychologists.

All of us also conduct private practice (and were so engaged before the advent of Medicare rebates for psychology), treating patients with a range of presentations including substance misuse, complex trauma histories/experiences, severe anxiety and depressive disorders, personality disorders, and self-harm/suicide behaviours. The bulk of our patients have long standing difficulties which have severely decreased their quality of life and ability to support themselves and their families without a significant level of government and Centrelink assistance. As a consequence, the majority of these patients are bulk billed through Medicare to ensure increased access to specialist services by those who can least afford to access them privately. Two of us provide services in the North Western suburbs of Melbourne which are amongst the most disadvantaged areas in the metropolitan region.

Patients with complex and chronic illnesses will be severely disadvantaged by the proposed reduction of sessions (from the current annual number of 18 in exceptional circumstances to a maximum of 10 per annum), since they often require at least 12 and sometimes more sessions

to address their difficulties appropriately and in a way that can assist them to improve their day to day functioning in the longer term. Should the proposed cuts to service availability be approved, then these patients may not be able to be ethically accepted for treatment – we know from our experience that the majority of moderately to severely unwell patients will need at least 12 sessions to make positive changes in their life.

Directing these patients to the ATAPS programme will mean that they may well be treated by those without specialist, quality controlled, training and expertise in diagnosis, assessment and treatment of mental health problems, such as is provided by an appropriately trained and PsyBA endorsed Clinical Psychologist.

The evaluation of the Better Access programme had serious methodological flaws which do not appear to have been fully considered. For example, the reasons for some people attending only 1-2 sessions of treatment were not explored. It may be that these patients were dissatisfied with their treating professional (whose professional training background was apparently not factored into the evaluation). Since all of us (and many of our colleagues) have seen patients who have been previously treated by a non-specialist psychologist, and who have been dissatisfied with the treatment provided to them, it may be that this was a factor in the high percentages of low attendance found in the ‘evaluation’.

Endorsed Clinical Psychologists are the only mental health professionals subject to rigorous monitored professional development in relevant areas (i.e., mental health) requirements following graduation from an approved post graduate professional degree. These requirements must be met for specialist endorsement to be maintained. There is no guarantee that a non-specialist professional has appropriate levels of expertise.

The call for the abolition of the two-tier rebate (by those primarily non-endorsed specialists) downgrades the expertise and investment in basic training undertaken by those who have followed the endorsement route and become specialists. The difference can be appropriately conceptualised in terms of the difference between a general practitioner and a specialist medical professional. Certainly, general practitioners provide a valuable service to many people with less severe issues (or monitor individuals in between specialist visits), as do those mental health practitioners without specialist endorsement. However, to suggest that the training and expertise of a specialist medical practitioner has not ‘earned’ a higher reimbursement schedule than that of a general practitioner is inappropriate. Certainly the medical profession accepts that all medical professionals are not the same. We are fairly

certain that those non-endorsed psychologists who are calling for the abolition of the two-tier rebate would prefer to have a serious medical condition (e.g., cardiac problems, cancers) treated by a specialist rather than a general practitioner, and would happily pay for the extra expertise yet they are calling for mental health service providers to be treated as 'all the same', and denying differences in approaches and expertise. This seems to be somewhat demeaning and minimising of the complexity and severity of client presentations that can occur in mental health conditions, as well as of their 'colleagues' in the psychology profession.

Any cut to the present maximum of 18 permissible annual Medicare subsidised consultations directly undermines the most unique contribution of the Clinical Psychologist to evidence-based and scientifically-informed mental health treatment. The most vulnerable population cohort will be those who cannot afford to fully pay for their remaining mental health treatment. It is extremely disappointing that the government is proposing to introduce inequality into the provision of mental health care in Australia, by reducing the number of psychological treatment sessions available to patients through Medicare.

Many of the current patients we see would formerly have been eligible to be treated in public mental services (who continue to be overloaded with demand exceeding service availability) or have been discharged following brief treatment. Clients such as this are appropriately treated by specialist clinicians, who can also provide support and advice to the treating general practitioner. Should the proposed cuts to annual entitlements to Medicare rebateable sessions and the proposed abolition of the two-tier rebate go ahead, then bulk-billing by specialist clinicians will cease to be a viable option, thus further reducing service accessibility. In addition, the clinician will need to consider if it is ethically appropriate to commence service provision with someone whose needs will obviously exceed the maximum of 10 sessions, and who is not in a position to pay for services at all. Psychiatrists are in short supply and often charge substantial fees beyond the reach of most mental health clients in the more disadvantaged areas of Victoria (North Western suburbs, outer suburbs and rural areas). Thus, with limited access to specialist mental health care in the private sector (should the proposed cuts be adopted), then they will just have to manage as best they can. This is clearly not an ideal situation in Australia in 2011.

Apart from Psychiatry, no other discipline receives as advanced training across the lifespan and the entire spectrum of complexity and severity of mental health disorders as the Clinical

Psychologist. It is the only allied health discipline whose entire postgraduate training is in the field of advanced evidence-based and scientifically-informed mental health assessment, diagnosis, case formulation, consultation, treatment, evaluation and research. Selection procedures are extensive and rigorous, and trainees' performance is continuously monitored and evaluated in terms of theoretical knowledge and the understanding and ability to translate theoretical and research knowledge into effective interventions tailored to each client's individual needs, regardless of the level of severity of their disorder. As a consequence of the rigour of the training and the high levels of expertise developed, a Clinical Psychologist is able to effectively treat clients with mild and moderate difficulties as well as those with the most complex and severe mental health presentations.

The extent of the skills of the Clinical Psychologist was highlighted by the investigation of the Management Advisory Service to the NHS, in 1989. This investigation considered the differentiation of the health care professions according to skill levels. Skills in this sense referred to knowledge, attitudes and values, as well as discrete activities in performing tasks. The group defined three levels of skills as follows:

Level 1 - "Basic" Psychology – activities such as establishing, maintaining and supporting relationships; use of simple techniques (relaxation, counselling, stress management)

Level 2 – undertaking circumscribed psychological activities (e.g. behavioural modification). These activities may be described by protocol

Level 3 – Activities which require specialist psychological intervention, in circumstances where there are deep-rooted underlying influences, or which call for the discretionary capacity to draw on a multiple theoretical base, to devise an individually tailored strategy for a complex presenting problem. Flexibility to adapt and combine approaches is the key to competence at this level which comes from a broad, thorough and sophisticated understanding of the various psychological theories.

The group suggested that almost all health care professionals use level 1 and 2 skills and some have well developed specialist training in level 2 activities. The group went on to argue that clinical psychologists are the only professionals who operated at all three levels and (I quote) *"it is the skills required for level 3 activities, entailing flexible and generic knowledge and application of psychology, which distinguishes clinical psychologists..."*

Overall, this review confirmed that what is unique about a clinical psychologist is his or her ability to use theories and concepts from the discipline of psychology in a creative way to solve a range of problems in a variety of clinical settings.

Clinical Psychology requires a minimum of eight years' training and is the only profession, apart from Psychiatry, whose entire accredited and integrated postgraduate training is specifically in the field of lifespan and advanced evidence-based and scientifically-informed psychopathology, assessment, diagnosis, case formulation, psychotherapy, psychopharmacology, clinical evaluation and research across the full range of severity and complexity of client presentations. Moreover, Clinical Psychologists are well represented amongst the innovators of evidence-based therapies, NH&MRC Panels, other mental health research bodies and within mental health clinical leadership positions. Interventions developed, evaluated and provided by clinical psychologists have been shown to decrease health care costs by decreasing inpatient bed days and other medical services (Milgrom, Walter, & Green, 1994). A UK review in 1990 also found that brief psychological interventions can reduce the use of other health services, making savings which are greater than the cost of providing psychological services, the 'medical off-set' phenomenon (The British Psychological Society). In addition, interventions that have been developed and/or implemented by a clinical psychologist can have a major impact upon the physical (Touyz, Blaszczynski, Digiusto, & Byrne, 1992) and psychiatric health of individuals (Watts). Treatments developed include those for disorders as severe anxiety disorders (including severe obsessive-compulsive disorder and post-traumatic stress disorder), depressive illness, chronic pain syndromes, eating disorders, chronic personality disorders, and substance misuse, as well as the management of symptoms associated with schizophrenia (Chambless et al., 1996, King & Ollendick, 1998). In addition, skills are readily applied to the treatment of the higher prevalence disorders.

In summary, if the proposed changes to the current Better Outcomes in Mental Health scheme are implemented, then the more vulnerable individuals in our community will be significantly disadvantaged in terms of access to quality mental health services in the private sector. Those individuals in the lower socio-economic groups are likely to be particularly disadvantaged, and may, in fact, be amongst those most in need of specialist mental health care.

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