Submission to the Commonwealth Funding and Administration of Mental Health Services

Senate Inquiry: Community Affairs References Committee

Dear Committee Secretary

I submit the following response to the Senate Inquiry into Commonwealth Funding and Administration of Mental Health Services. My submission will focus on my concerns regarding changes to the following areas of enquiry in particular b (ii) the rationalisation of treatment sessions and (i) the two-tiered Medicare rebate system for psychologists.

As a Clinical Psychologist practicing in the state of Western Australia, I have practised in the area of psychology since 1999. My employment roles have been varied and include such roles as a behavioural therapist, counsellor in a mental health clinic and child and youth counsellor when qualified as 4 + 2 trained psychologist. Since completing post-graduate training in Clinical Psychology (6+2 trained psychologist) I have also held such roles as a hospital based Clinical Psychologist, Clinical Psychologist providing post-discharge support for recent mental health inpatients and also as a Clinical Psychologist in private practice providing service to clients mostly referred via the Better Access Scheme. My response to the Committee will draw on these 12 years of experience in a variety of psychology roles with varying degrees of training and expertise.

(ii) the rationalisation of allied health treatment sessions, in the context of reduction of session numbers to 6 +4;

In the terms of reference stated by the committee, discussion of session rationalisation was presented as distinct to mild and moderate presentations are distinct from severe mental health disorder presentations. Clinical psychologists are trained to treat individuals who present with mild, moderate and severe mental health disorder across the lifespan. Clinical Psychologists are rigorously trained in the area of mental health. Although often grouped with Allied Health for administrative purposes, Clinical Psychologists differ in many ways from other Allied Health professionals. No other allied mental health professional receives as high a degree of education and training in mental health as the Clinical Psychologist. Other than psychiatry, Clinical Psychology is the only mental health profession whose complete post-graduate training is in the area of mental health. Furthermore, it is the only discipline whose complete training is in psychology, that is, both at the undergraduate and post-graduate level. In other words, the Clinical Psychologist is completely trained in a science intrinsic to mental health (1998, Work Value Document, Western Australia Clinical Psychology Health Sector, p.30). Because of this recognition of skills and training, Clinical psychologists attract referrals from GPs for patients with severe mental health disorder via the Better Access Scheme. Most clients I see are in the moderate to severe in their presentation. It concerns me that sessions are set to be reduced particularly when I consider the needs of those in the moderate- severe group.

Currently patients are offered access to a rebate for 6 clinical psychology sessions with the potential for further extension to 6 -12 sessions (or 18 in total)for those patients with more severe and persistent and enduring presentations. Clinical Psychologists are funded to provide psychological therapy, most often cognitive behavioural therapy and interpersonal therapy to referred patients. Whilst many patients, particularly those presenting after a recent crisis do well in less than 6 sessions, those presenting with more complex and longstanding mental health disorders such as recurrent depression, bipolar disorder, panic disorder, post-traumatic stress disorder, eating disorders or mental health disorder comorbid with personality disorder and/ or addiction generally require greater than 6

sessions. Gold standard therapy models of cognitive behavioural therapy in which treatment and relapse prevention is offered are a 12 session model. Reducing sessions offered to a maximum of 10 sessions (6+4) means rationalising treatment for patients, reducing frequency of sessions or minimising relapse prevention at the end of treatment. The cost effectiveness of this in the short term in my opinion will be outweighed in the long term by the ramification of incomplete treatments when these patients must return to regular avenues of support post-discharge from psychological therapy such as increased visits to their GPs, increased emergency department presentations, increased absenteeism from work.

Further to this, treatment may have unintended negative consequences for more complex patients if sessions limits require that treatment be ceased prematurely; for example, reinforcing long-standing patterns of isolation, rejection/abandonment and hopelessness. For these reasons many psychologists have raised serious concerns regarding the ethics of providing treatment to such patients referred to them under the Better Access Scheme, if the new session limits are to be implemented

There are a number of patients seen by Clinical Psychologists via the Better Access Initiative who present with severe mental illness who do not meet the criteria for mental health clinics and other publicly funded mental health initiatives. Due the nature of demand for services, mental health clinics often have stringent criteria for access and patients are waitlisted for varying times. Due to the time intensive and relationship focussed nature of the work, clinical psychology services have long wait lists for eligible patients. Many of the clients that I have seen via the Better Access Initiative would not meet criteria for access to a publicly funded mental health clinic, however they are experiencing severe levels of distress and are often not able to function in their usual role at the time of accessing therapy. For some patients with recurrent and long standing mental health difficulties, the contact with me has been their first opportunities to access treatment outside of GP support, emergency departments and medication options.

Whilst it is important for the government to continue to improve funding to a range of mental health services targeting people with severe mental health disorder, reducing the number of sessions to 6+4 a total of 10 will reduce the access that individuals with severe mental illness have to clinical psychology services. The costs to the government of incomplete treatments due to early than is optimal discharge will occur as patients return to regular avenues of support post-discharge from psychological therapy such as increased visits to their GPs, increased emergency department presentations, increased absenteeism from work.

(i) the two-tiered Medicare rebate system for psychologists.

I support an ongoing distinction in the rebate for Clinical Psychologists. To support of my argument I will focus on the role of the Clinical psychologist in the assessment and treatment of mil, moderate and severe mental health disorder as distinct to 4+2 trained psychologists, my experience as a 4+2 trained psychologist employed in a mental health clinic as opposed to my current role as a Clinical Psychologist, the impact the two-tier system has in encouraging higher standards in psychological standards in Australia and adequate remuneration of Clinical Psychologists.

The role of Clinical Psychologists in the area of assessment and treatment of mental health
Clinical Psychologists have specialist training and experience in the assessment and treatment of mental health disorder across the spectrum of mild, moderate and severe mental health disorder. Clinical Psychologists undertake rigorous and intensively monitored training in order to obtain their qualification and title in the state of Western Australia. Clinical training focuses on assessment and intervention of clinical mental health disorder, ethical and legal issues, experience with diversity of clients across cultures and the lifespan. Training includes student placements in clinical workplace settings.

In 1989, the Management Advisory Service to the NHS in the UK differentiated 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 National Health Service Review of Psychological Services directly outlines and states that in their review they found that 4+2 trained psychologists are able to provide basic psychology services (Level 1) and behaviour modification (Level 2) but lacked the skill and knowledge to provide *"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 (Level 3) ."* In fact this review found that only Clinical Psychologists were able to provide the Level 3 intervention "it is the skills required for level 3 activities, entailing flexible and generic knowledge and application of psychology, which distinguishes Clinical Psychologists...".

The finding of this review was consistent with other reviews, such as the Work Value Case of Western Australia, (1998) ,which suggest that what is unique about Clinical Psychologists is his or her ability to use theories and concepts from the discipline of psychology in a creative way to solve problems in clinical settings. Further, it should be noted that in the United Kingdom and United States minimum standards for practice of psychology do not support or recognise 4+2 trained psychologists in the area of assessment and treatment of mental health disorder.

Given the above, it is important that strategies are determined to enable people with mild, moderate and severe mental health disorder to continue to engage with Clinical Psychologists to receive access to the better suited clinicians for treatment for their needs.

My personal experience as a 4+2 psychologist as compared to my current role as Clinical Psychologist in relation to workplace competence.

My personal experience when I was employed as a 4+2 trained psychologist echoes the findings of the reviews stated above. At this time, I was employed in a mental health clinic in a rural mental health service. I had basic counselling skills and knowledge of mental health disorder which I now recognise as I inadequate for the role required. I understood models such as behaviour therapy, cognitive behavioural therapy and client centred therapy but I did not have an adequate framework to assess and formulate a treatment plan for patients presenting with clinical presentations (i.e. nearly all of the patients presenting to the clinic) nor did I have an experience in applying these models. I also did not have the benefit of exposure to work placements as part of my training. I lacked the understanding of the assessment and treatment models to adequately select and tailor an intervention to a patients particular problems, particularly those with complex clinical presentations and those where developmental consideration and trauma played a role. In particular I struggled with comorbidity and patients who presented with personality characteristics that made it difficult for them to engage in more than basic psychological treatment. I had to learn on the job how to triage, how to manage suicidal clients and potentially dangerous clients. I also was not familiar with ethical and legal issues, these were all learnt on the job and through supervision and sometimes not adequately taught. It was the recognition of these knowledge and skill deficits that led me to undertake further training and become a Clinical Psychologist. It concerns me to think that my competence was defined by the knowledge and skill of one supervisor who was also 4+2 trained. It also concerns me

that in the current system, I could now be working as a solo practitioner providing Medicare rebated services with the low standard of skills, knowledge and competency I described above.

On completion of my clinical psychology training in which my practice was supervised by no less than 6 clinical psychologists and observed by many more clinical psychologists and psychiatrists whilst on placement. I entered the workforce ready to assess, treat and triage patients. I had the competence and skill I needed to work both in a psychiatric and hospital setting. I continued to be supervised by a Clinical Psychologist for two further years.

As a Clinical Psychologist working in a private practice employing only Clinical Psychologists, we have attracted a reputation for successfully treating complex mental health disorder. Therefore the number of referrals we receive for people with complex mental health disorder continues to increase. It is my opinion that the specialist skills developed in training as a Clinical Psychologist is fundamental to the successful treatment of our patients which include patients with diagnoses of Obsessive Compulsive Disorder, post traumatic stress disorder, severe and recurrent depressive disorders, bipolar affective disorder, eating disorders, phobias, schizophrenia, personality disorder and addiction. Whilst a small and vocal minority of 4+2 trained psychologists point to evidence of similar outcomes between Clinical Psychologists and psychologists, an issue to consider is what type of referrals are the two types of psychologists receiving? In my view it is likely that GPs are referring patients with more severe mental health disorder to Clinical Psychologists given the recognition of their expertise in assessment and treatment of these disorders. Further the

The two tier system as a vehicle to encourage and promotes a much needed higher standard of training for Psychologists

Australia falls well beneath world standards for standards of training for psychologists. In some ways allowing 4+2 trained psychologists to practice under Better Access contributes to the maintenance of this lower standard. However, the Australian Psychological Society reports (InPsych, 2011) by the recognition of clinical psychologists advanced knowledge, skills and training of clinical psychologists through the two tier rebate greater numbers of psychologists are seeking to enter postgraduate clinical psychology training. This is likely to result in the provision of more psychologists with increased skill levels in the assessment and treatment of people with mild, moderate and severe mental health disorder. Higher rebate for Clinical Psychologists encourages students and general psych to train as clinical psych. More psychologists than ever will soon be trained to practice the type of psychology required for patients targeted by better access initiatives. To equate 4 year trained and 6 year trained psychologists as equal in the Medicare system would result in a disincentive for students and existing 4 year trained psychologists to improve skills and training standards. Given the high costs of training in Clinical psychology, remuneration is an issue for those considering postgraduate training and as such the Medicare rebate needs to reflect a higher rebate for more suitably trained psychologists.

Current value for money provided by Clinical Psychologists providing services via Better Access

I would argue that the current clinical psychology rebate is provided at good value to the government when compared to the salaries of our public sector colleagues. The private sector practices and the clinical psychologists that work in them cover the costs and risks of providing clinical psychology treatment services. I propose that in order to continue to provide “better access” to low income earners, the clinical psychology rebate needs to be increased. To encourage better access to Clinical Psychologists the Medicare rebate should be lifted enabling more practitioners to see patients for closer to the bulk bill rate. Currently the bulk bill rate of $119.80 is not equivalent to pay rates for our colleagues in the Department of Health Western Australia and falls far short of the Australian Psychological Society recommended fee for 2011-12 is $218 for 50 minutes. Currently when I see a bulkbill client and associate fees of 40% are accounted for (this is a standard rate for associates covering administration, reception, rent, supplies etc) the remainder is $71.88. This fee covers time

spent in session, time spent preparing for the client session and time spent preparing reports and clinical record keeping, consultation and liaison and clinical supervision when required. The Australian Psychological Society recommended fee of $218 for 50 minutes recognises that 60% of a psychologists time is spent in session and 40% of psychologists working time is spent in preparation, clinical record keeping report writing and other relevant psychological activities.

The fee I receive does not provide coverage for risks such as no fee payment due to cancellation, non-attendance or payment difficulty, there are no annual leave or sickness benefits and no superannuation is provided. I incur additional costs when I attend professional development days via lost income and the cost of the training. I also must pay my own professional indemnity insurance and I choose to contribute to my own superannuation fund. By contrast, similarly experienced Department of Health Clinical Psychologist colleagues are paid annual salaries of between 103000 - 115000 dollars per annum pro rata plus 9% superannuation. For a clinician whose salary is 115 000 dollars this equates to an hourly rate of approximately $63.43 (inclusive of superannuation) for each and every hour they work. This hourly rate covers all of the time spent in activities relevant to clinical practice by a Clinical Psychologists and includes payment for cancellations and non-attendance, report writing and clinical record keeping, paid time for professional development, time in lieu arrangements and paid sickness, carers and annual leave payments. Additionally many of our Clinical Psychologist colleagues in public service are funded to attend professional development and their professional indemnity insurance is covered by their employer.

I have recently determined that I can no longer afford to see bulk billed patients as the current remuneration is inadequate. I predict that any reduction in the rebate would most likely see a large number of Clinical Psychologists returning to the public sector as it would become financially punitive to continue to provide private clinical psychology services.

In summary, I urge the Senate Committee to consider the costs to the public of rationalising session numbers and reducing access to Clinical Psychologists. I encourage the Senate Committee to continue to recognise the specialist knowledge and skills of Clinical Psychologists as best suited to assess and treat people experiencing moderate to severe mental health disorder. Additionally I urge the committee to reflect on the recommendations of the Australian Clinical Psychology Association’s submission which I support and which I believe will improve the Better Access program.

The Better Access Scheme has been very successful and I feel privileged to have been a part of this transition in Australian psychological history. I am hopeful that the contribution of my Clinical Psychology colleagues in provision of treatment to individuals who are experiencing psychological distress is recognised by the Senate Committee in their findings. Thank you for considering my submission.