

26<sup>th</sup> July 2011

Dear Sir/Madam,

I am writing to you as a concerned Clinical Psychologist who provides clinical psychology services both in the private sector and for a not-for-profit organisation. I would like to comment on two of the Terms of Reference of the inquiry into the Commonwealth Funding and Administration of Mental Health Services: the two-tier system of funding for psychologists and the proposed cuts to the rebated session numbers.

### **1. The two-tier system of funding**

In my work in the private sector the vast majority of the clients I see are bulk-billed, only a very small number pay a 'gap' payment. The majority of the clients I see are unemployed or on very low incomes and the majority have a dual diagnosis of mental health problems (such as schizophrenia, bipolar disorder, major depression, panic disorder, generalised anxiety disorder, post-traumatic stress disorder, personality disorders) and a disability (such as Asperger's Syndrome, Learning Disorder, Intellectual Disability, Cerebral Palsy). The majority of the clients I see have more than one mental health diagnosis. The vast majority have experienced mental health problems for many years, sometimes for most of their lives. Many of the clients I see have histories of experiencing abuse, including neglect, sexual abuse, physical abuse and emotional abuse. Other complex issues are very common in the clients I see, including dysfunctional relationships, difficulties with parenting, financial hardship, domestic violence, difficulties with housing, difficulty obtaining and maintaining employment, difficulty engaging in study and training, offending behaviour, interpersonal conflict and difficulty engaging in the community.

As you can understand from what I have described above the presentations are very complex and they require a clinician who has specialised knowledge and training.

As a Clinical Psychology I have completed eight years training. This includes six years of tertiary education (bachelor, honours and master's degrees) as well as two years supervised practice that included regular supervision with a clinical psychologist and further professional development through attending formal training. Clinical Psychology 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. We are well represented in high proportion amongst the innovators of evidence-based therapies, NH&MRC Panels, other mental health research bodies and within mental health clinical leadership positions.

It is important to keep in mind that the Medicare rate for Clinical Psychologists does not only fund the hour spent with the client. For every hour I spend with my client, I spend at least one hour (sometimes much more) actively contributing to that client's treatment. For instance, I complete session plans, I create resources to use with the client in the session, I purchase and prepare material to give to the client (such as books, CDs, handouts), I score and interpret assessment measures that I administer to the client, I provide between session support to the client through email and phone calls, I liaise in writing, in person and over the telephone with other professionals involved in the client's care, including case managers (such as from Disability SA and Disability Job Services Providers), psychiatrists, General Practitioners, and other allied health professionals. I also involve family members and partners where appropriate (this is often very important when working with clients with disabilities).

I also attend regular professional development and clinical supervision. As a Clinical Psychologist there are strict requirements about regular attendance at these activities and the criteria are specific about the type and content of training that must be completed. When I complete these in relation to my private work I do not get paid, and I also obviously pay to attend training and in the past I have also paid for clinical supervision.

As a Clinical Psychologist I also have significant fees related to registration as a psychologist with the Psychology Board of Australia, membership of the Australian Psychological Society (APS), membership of the Clinical College of the APS, and purchasing resources. These expenses are not covered by my organisation.

If the two-tier system is changed, it will be very difficult for me, and other Clinical Psychologists, to continue providing the specialised service described above. I believe that changing the funding will make it far more difficult for clients to find psychologists who are willing to bulk-bill them. Unfortunately for many clients a 'gap' payment for psychology services prohibits them from accessing a psychologist.

The Australian Psychological Society recommended rate for a 46 – 60 minute consultation with a psychologist is \$212. This rate takes into account the level of skills, experience, and training of the psychologist, as well as the work completed outside of the session, as well as all the other expenses described above. The current Medicare rate for Clinical Psychologists for a 46 – 60 minute consultation is \$119.80. This is very different to the recommended rate. To further reduce this rate would further devalue the services of the Clinical Psychologist. I believe it would encourage Clinical Psychologists to leave private work to be more adequately reimbursed for their services in other sectors. This would ultimately disadvantage clients as it would leave a shortage of Clinical Psychologists willing or able to provide services at the bulk-bill rate.

Some information about Clinical Psychology as a profession as separate to other specialisations in psychology (from the American Psychological Association website):

Clinical Psychology is a general practice and health service provider specialty in professional psychology. Clinical psychologists assess, diagnose, predict, prevent, and treat psychopathology, mental disorders and other individual or group problems to improve behaviour adjustment, adaptation, personal effectiveness and satisfaction.

What distinguishes Clinical Psychology as a general practice specialty is the breadth of problems addressed and of populations served. Clinical Psychology, in research, education, training and practice, focuses on individual differences, abnormal behaviour, and mental disorders and their prevention, and lifestyle enhancement.

## Parameters to Define Professional Practice in Clinical Psychology

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The following are the parameters.

### Populations

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Clinical Psychology services involve the application of psychological principles to the assessment and alleviation of human problems in individuals, families, groups, and communities. Clinical psychologists focus on services to individuals of all ages and may work with a single individual or with groups or families from a variety of ethnic, cultural and socioeconomic backgrounds who are maladjusted or suffer from mental disorders. Populations include those with medical problems and physical disabilities, as well as healthy persons who seek to prevent disorder and/or to improve their adaptation, adjustment, personal development and satisfaction.

### Problems/Issues

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As a general practice specialty, Clinical Psychology focuses on the understanding, assessment, prediction, prevention, and alleviation of problems related to intellectual function; emotional, biological, psychological, social and behavioural maladjustment, disability, distress, and mental disorder and, therefore of necessity, enhancement of psychological functioning and prevention of dysfunction.

### Procedures

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Assessment procedures include

- Structured and unstructured interviews
- Measures of intelligence and achievement
- Objective and projective personality tests
- Direct observation
- Functional analysis of behaviour and behavioural rating scales
- Tests of cognitive impairment and higher cortical functioning
- Physiological measures
- Analysis of archival data
- Milieu measures

- Batteries of techniques consisting of one or more of the above

Intervention procedures from a variety of theoretical orientations include individual psychotherapy, group therapy, couples therapy, and family therapy, as well as personal enhancement interventions. Clinical psychologists also develop, administer, supervise and evaluate inpatient intervention programs, community prevention and intervention programs, and skills training programs, among others.

Consultation regarding the breadth of problems addressed is provided to other health care professionals, educational personnel, social service agencies, nursing homes, rehabilitation centres, industry, legal systems, public policy makers, and other institutions.

Supervision is provided to psychological technicians, psychometricians, biofeedback technicians, other persons who provide psychological services, health care professionals from other disciplines, and psychology trainees in practicum, internship and postdoctoral settings. Clinical psychologists also supervise clinical research, and carry out administrative activities, teaching and clinical supervision.

Research is a core activity of Clinical Psychology, and includes

- The development and validation of assessments and interventions related to intellectual, cognitive, emotional, physiological, behavioural, interpersonal and group functioning
- Basic research in personality, psychopathology prevention, and behaviour change and enhancement
- Program evaluation
- The review, evaluation, critique and synthesis of research

## **2. The proposed cuts to the rebated session numbers**

I have significant concerns about the proposed changes in which (Better Access) Medicare rebates for clinical psychology services have essentially been reduced by 45% from 12 plus 6 extra sessions for those in need to a maximum of 10 sessions per annum. I find it puzzling that the federal government seems to believe that only those with mild to moderate issues seek help from private clinical psychologists, or can respond favourably to these evidence-based interventions. This is despite evidence from the program to date that outlines the use of services, the level of distress and symptoms from standardised assessment measures at baseline, and the improvement in symptoms with treatment.

As I have described above the vast majority (if not all) of the clients I see in the private sector have mental health problems in the moderate to severe, and in some cases extremely severe, end of the spectrum.

We are all acutely aware of the prevalence of psychological disorders in the Australian population. For example, the 2007 National Survey of Mental Health and Wellbeing conducted by the Australian Bureau of Statistics found that an estimated 3.2 million Australians (20% of the population aged between 16 and 85) had a mental disorder in the twelve months prior to the survey. Similarly, an Australian

primary care study found that 36 per cent of those attending primary care settings have symptoms of psychological disorder and 20.5 per cent report both anxiety and depressive disorders (Harris et al., 1996). A significant proportion of these members of society may benefit from treatment, thereby improving quality of life, productivity, and general wellbeing of individuals and families. The support provided by the Better Access scheme will be central in addressing the mental health needs of Australians in the future.

I choose to offer bulk-billed (or 'gap' free) services in order to provide services to those who are otherwise unable to afford intervention, and for whom public services are often not available, have long waiting lists, or are not services that have the level of expertise in CBT. As you may imagine, those in the lower socio-economic groups that are then the majority of referrals tend to be those who may also have multiple psychosocial stressors that significantly impact on their mental health, and will often present with multiple symptoms and disorders, of often longstanding duration that require greater input than the suggested 6-10 sessions per year. These clients are also those who will be unable to privately afford ongoing intervention following the brief therapy opportunity under the proposed new Better Access provision. Nevertheless, in the past, in this client group the 12-18 session plan would tend to significantly improve both symptoms and functioning in the majority of clients, who are also extremely appreciative of the services provided.

As well as providing private services two days a week, three days a week I work as the only psychologist in a not-for-profit NGO that works with young people experiencing difficulties related to homelessness, family conflict and violence, significant drug and alcohol use, offending and criminal behaviour and past trauma and abuse. As the only psychologist I am not able to see clients for long-term support so many clients have been able to see local psychologists who bulk-bill, which is excellent. As you can imagine these young people really need regular and frequent psychological support and 10 sessions a year just is not enough to address their complex problems. Especially when there is the need for close monitoring of the risk of suicide and self harm. I have found in my private practice work most clients do not need more than 12 sessions a year but in some situations (such as when the client is at risk of harming themselves or others) the additional sessions under "exceptional circumstances" are extremely beneficial for the client.

Research typically supports CBT intervention for between 12-20 sessions for most single-disorder presentations. I then fear that we will have compromised clinical outcomes for many clients with a 6-10 session limit (including assessment), then placing more demand on the public sector that has limited specialist treatment centres. Alternatively, clients will remain at significant risk of relapse with fewer skills in managing their symptoms in the longer term, which will then be likely to translate to increased health costs and poorer clinical outcome in the longer term. I believe that the current proposal lacks insight into some of these processes, and wish to express my concerns on behalf of future clients. Essentially it is the consumers who are going to suffer.

When I wrote to Kate Ellis with these concerns the response was that if clients require more than 10 sessions they can then receive services from a psychiatrist. I believe this demonstrates a real lack of understanding of the therapeutic process that a psychologist takes part in and in the role that psychiatrists play. The therapeutic relationship is so important in the therapy process. Some studies have shown that up to 40% of the change shown in therapy can be attributed to the therapeutic alliance between the client and therapist. After 10 sessions of building a therapeutic relationship (including a relationship of openness and trust) it could be extremely unhelpful, and in some cases damaging, to end therapy with that client and expect them to start afresh with a psychiatrist. In addition, psychiatrists do not offer the same treatment that Clinical Psychologists do. Generally due to busy workloads they have less time available for the clients and see them less regularly. Often their primary treatment is providing medications. They generally do not provide CBT. Psychology and psychiatrist services often work well in conjunction with each other; it is not one or the other. And one does not replace the other.

I sincerely hope that the Federal Government sees the short-sightedness of significantly reducing access to specialist psychology services, as well as changing the two-tier payment system, and changes its stance on these speciality services for those in need.

Yours Sincerely,

Clinical Psychologist