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Inquiry into Commonwealth Funding and Administration of Mental Health Services

The Government of Australia is applauded for placing mental health high on the agenda of the 2011-2012 budget.

However, attention is drawn to a potential risk of losing a most valuable element in the armoury of mental health services. The Australian people waited unduly long as compared with people in many other countries to have therapeutic and treatment Clinical Psychology services available to them in community settings when a mental health need arose. Finally, some access to these services occurred when the Medicare rebates were brought in, although there was still a problem with the number of sessions being covered. The particular nature of these services and their effectiveness in treating mental illness has contributed to a revolution in mental health care throughout the world over the last few decades and Clinical Psychology has come to be accepted as offering front line treatment, especially when combined with medical, psychiatric and supportive services, leading to full recovery or substantial improvement in many cases including some severe conditions. If these services are cut back to make way for more support services to be delivered through Medicare Locals by “ATAPS” allied mental health professionals, it will be a most backward step and a great embarrassment to Australia. However, this does not seem to be in the spirit of the Government’s intentions of improving services to people with mental illness. While the Government is re-structuring mental health services throughout Australia, it is the ideal time to enhance the availability of proper Clinical Psychology

treatments. Recommendations will be made for relatively minor adjustments to the Government's proposals to ensure that optimal outcomes are achieved.

The writer

I am a Clinical and Forensic Specialist Psychologist with endorsed registration in these specialist areas of practice. I am a Fellow of the Australian Psychological Society (a rare honour held by fewer than 250 psychologists in a membership of over 20,000) and I hold the office of Chair of the Board of Assessors of the College of Clinical Psychologists within the Australian Psychological Society, over-seeing the assessment of psychologists applying for College membership and Clinical Psychology rebates who have not undertaken the standard training in Clinical Psychology. This process is now in its closing phase as the Psychology Board of Australia assumes governance of specialist endorsements of registered psychologists. I was co-author of the first submission to government for the inclusion of Clinical Psychology rebates in the Medical Benefits Schedule in 1984. As well as practising Clinical Psychology at the Repatriation Hospital, Heidelberg and the Austin Hospital and in independent practice, I was involved in setting up the Clinical and Forensic post-graduate programs at Deakin University in the mid to late 1990s and taught in them until I left the University in 2003 to expand my practice.

Including Terms (e) (i) and (b) (iv):
Ambiguity in the Government's proposals regarding General and Clinical Psychology Services.
The two tiered systemn of payment for psychology services and reference to changes in the number of sessions for Allied Mental Health services

Much is said in the budget about re-structuring mental health support services at the Primary Care level and the rolling out of Medicare Locals to facilitate good co-ordination of services, including the funding of "ATAPS" for targeted patient groups. However, specific treatment of mental illnesses is not addressed, and Clinical Psychology Services are not mentioned. It is noted

that there are separate item numbers in the Medical Benefits Schedule for General and for Clinical Psychology services and ***different services to be provided.*** It is not just a two tier payment system for those with higher qualifications, but a use being made of the advanced knowledge and skills relevant to mental health service delivery which is sought from the Clinical Psychologist. General Psychologists are to provide Focused Psychological Strategies along with a number of other Allied Mental Health Professionals, whilst Clinical Psychologists are to provide Assessment and Treatment of, or Therapy for, Mental Disorders. Clinical Psychologists are not referred to as Allied Mental Health Professionals in the Medicare Benefits Schedule where General Psychologists are classified in this way.

It is important in making changes to the administration and funding of mental health services that the distinction is made between full treatment interventions (scientifically developed to reduce symptoms and even eliminate or cure the mental illness) and supportive services (which assist the patient to cope with their condition and improve their quality of life). Both types of services are valuable in the mental health field.

Over the last 50 years world wide the discipline of Clinical Psychology has been developing active treatment interventions which are effective for many mental illnesses. There are a number of international journals of Clinical Psychology which publish this research, and the Australian journal, *Clinical Psychologist*, has recently been accepted for listing of its impact factor in two scientific citation indices and two Current Contents summary journals, demonstrating the world class standard of Clinical Psychology in Australia. Clinical Psychologists have been working in hospitals and community mental health services in Australia for several decades, but it was not until the introduction of the Medicare items that these services were readily available to the general Australian public. Australia was far behind other comparable countries before this took place, and it is vital that no set-back occurs now. Term (b) (iv) could be thought to indicate that only Allied Mental Health Professionals are having their session numbers reduced, but then it calls

these “treatment” services, where they are simply Focused Psychological Strategies.

At the inception of rebates for Clinical Psychology services the number of sessions was insufficient to allow treatment to be completed in a significant minority of cases, and treatment had to be arbitrarily curtailed. This contributes to the perception that mental illness tends to be persistent and prone to a high rate of relapse. It also reduces public confidence in the effectiveness of Clinical Psychology treatments. Ultimately it can be regarded as unethical to begin a treatment you will not be able to complete. It might not be too difficult to imagine that 10 or 12 sessions might not be sufficient (even when combined with medical, psychiatric and/or support services) to achieve a stable recovery in an alcoholic consuming two bottles of wine or more a day at the commencement of treatment, or a person so depressed that they cannot go to work or carry out chores around the home. Yet these might well be treatable cases, which without proper treatment, may deteriorate further and suffer their condition long term with quite a dysfunctional lifestyle. It is considered that 30 sessions might be needed in the first year of treatment, and with good progress, maintenance services on a monthly basis might be required for a further six to 12 months. With less than this, you have a formula for relapse, which has been so commonly seen in these conditions in the past.

Upon reading the budget, alternative interpretations regarding Clinical Psychology services under the Medicare Benefits Schedule could be made. One interpretation is that as there has been no mention of these services, that no changes were intended. The other is that the distinction between Clinical and General Psychology services has been overlooked, and a simplified, global concept of all psychological, and even all allied mental health professions, has been adopted. This simplification, if left unchecked, could lead to the loss to the Australian public of the availability of active treatment interventions for common mental illness in the community sector.

However, once the Terms of Reference for the Committee were set out, Term (e) (i) “the two-tiered Medicare rebate system for psychologists” suggested that merging of the concepts was occurring, with the dangers of destroying what had been begun under Medicare of providing active treatment services instead of building on it.

Also, Term (b) (iv) refers to “treatment” services offered by Allied Mental Health Professionals under the Medical Benefits Schedule, where these services are just Focused Psychological Strategies.

Term (d): Services to those with severe mental illness

The Government’s concept of the roles of Primary Care through “ATAPS” and the role of the Medicare Benefits Schedule items seems to lead to a contradictory situation whereby patients with a more severe or complex presentation are to be handled at the Primary Care level while those with milder conditions can see a Specialist Clinical Psychologist for treatment. This does not seem to be the right arrangement. Rather, mild cases can be seen by General Psychologists under Medicare rebates (unless they meet a criterion for “ATAPS”) for Focussed Psychological Strategies which may deal with a singular problem, or with a little help, allow a mild condition to show recovery by a placebo effect or spontaneous remission. Moderate and severe cases should be referred to a Clinical Psychologist under Medicare rebates for specific therapy and treatment of their mental disorder, with sufficient sessions being allowed for treatment to be completed. Clinical Psychology services are not covered under “ATAPS” as they are a specialist service rather than a primary care service and no financial allowance is made in “ATAPS” for any specialist service as they operate Primary Care.

An erroneous fusion may have developed between the concepts of a persistent and intractable condition which will not respond to active treatment and the severity of a condition. These aspects of any condition are not the same, but they seem to have been treated interchangeably in the Government’s proposals. This leaves the person with a severe but treatable

condition unable to access adequate treatment. It seems wrong to send the *treatment* of the most severe cases to the Primary Care level, who can only offer Focused Psychological Strategies. Only those whose condition is intractable should be managed at Medicare Locals with support services.

Overall, due to a fusion between the concepts of severity and persistence, no allowance has been made in the Government's proposals for those with severe or complex presentations to have sufficient treatment by a specialist Clinical Psychologist to recover from their condition.

Term (e) (ii): Training and Qualifications

The difference between Clinical and General Psychologists can be seen in their training programs and can be confirmed through examination of the syllabuses of, on the one hand, under-graduate and Graduate Diploma or Honours programs in most Australian Universities and, on the other hand, those Universities offering Clinical Masters and Doctoral degree programs. This information can be found on the University websites. The training of General Psychologists does not include any placements in mental health settings and only a single unit of theoretical study of abnormal psychology, psychological assessment (e.g. IQ and personality testing) and counselling theories. There is no practicum applying assessment, diagnosis or treatment to patients with a mental illness. That is why General Psychologists should only deliver Focused Psychological Strategies in the mental health field. They may also work supportively with patients with severe and intractable conditions. Both General and Clinical Psychologists have two years of supervised experience after completing their University studies, but the work they are being supervised in doing is of a different level.

A complicating factor concerning General Psychologists is that half of them are specialists in another area of psychology, but their post-graduate training has not been exclusively and comprehensively focused on psychopathology, its assessment, diagnosis and treatment in the way that Clinical Psychology programs are. Furthermore, the operations of the Medicare Assessment Team at the Australian Psychological Society have meant that since the commencement of the

two-tiered rebates, psychologists have had the opportunity to have their Curricula Vitae evaluated for equivalence to the qualifications of a Clinical Psychologist, and some have been given an individual bridging plan to become a Clinical Psychologist.

It should also be noted that there are two other specializations of psychology in Australia which are directly concerned with health, Clinical Neuropsychology and Health Psychology, but their fields of application are different to mental health and these specializations should be considered for their own item numbers in due course. When such areas of health care are included in the Medicare system, Clinical Psychologists would be classed as General Psychologists for these purposes (if any General Psychology item numbers were created in relation to these areas).

It is hoped that the Government will not give any credence to those who are trying to claim no difference between General and Clinical Psychologists. To fail at this time in history to make available Clinical Psychology services to people with mental illnesses in a manner which allows treatment to be completed and be effective would place Australia in a seriously backward position in comparison with a great many other nations.

Term (e) (iii): Workforce

There is now a viable workforce of Clinical Psychologists where there was not at the time when Medicare Benefits were introduced. In line with the Government's support in creating more training places and funding the inaugural year of the Medicare Assessment Team at the Australian Psychological Society, the profession of Clinical Psychologists has grown to over 4000 practitioners able to deliver treatment for many mental disorders.

If 10% of the community carries a mental disorder at any one time as most epidemiological research indicates, and if these Clinical Psychologists delivered an average of 20 session of treatment working 30 hours a week of patient contact over 42 weeks of the year, (allowing for leave, professional development, public

holidays and sick leave), they would deliver a viable treatment to 252,000 members of the Australian public each year. Given that there are other services operating in mental health, this workforce can provide a significant contribution to mental health treatment in Australia. Clinical Psychologists trained with mental health placements, work closely with Psychiatrists, Paediatricians, General Practitioners and Allied Health Professionals. Numbers in the profession will continue to increase as new graduates emerge and gain specialist endorsement with the Psychology Board of Australia, and training programs can be adjusted as the workforce reaches an optimal level.

Term (a): Costs Cosiderations

One saving that may be made could be that when referring to a Clinical Psychologist a Mental Health Plan may not be called for, unless a range of services is considered necessary for the patient. An ordinary referral letter would suffice. The Clinical Psychologist should be required to report back after the first session with diagnostic considerations and an initial treatment plan and maintain regular communications with the referring practitioner throughout treatment and a final report when treatment is concluded. The continuation of services could rely upon the referring practitioner agreeing that progress is being made or that there are exceptional circumstances which have delayed progress. The proposed reduction in the number of sessions for those attending a General Psychologist is acceptable, as this is sufficient for the delivery of Focused Psychological Strategies. It should be appreciated that increasing the number of sessions for Clinical Psychology services is only a small proportion of the workforce and that these services will reduce the call on “ATAPS”.

A major benefit of Clinical Psychology treatments is that there is inbuilt relapse prevention. As these treatments involve learning new attitudes, behaviours and conceptualisation of experiences, should another episode of the disorder occur, it is often far quicker to treat. A condition which took 20 or even 50 sessions to treat the first time may only take three to five or ten sessions on a subsequent occasion to reinstate the therapeutic interventions. This would be a major saving on mental health costs long term, and also a major reduction in human suffering.

Summary of Recommendations

1. Retain the distinction between services provided by General Psychologists and those provided by Specialist Clinical Psychologists.
2. Carry out the proposed reduction in session numbers for Allied Mental Health Professionals including General Psychologists to deliver Focused Psychological Strategies.
3. Provide the proposed funding of “ATAPS” through Medicare Locals with a possible slight reduction in this funding to allow for full treatment services to be delivered by Clinical Psychologists under the Medicare Benefits Schedule..
4. Increase the number of sessions for Clinical Psychology services to 30 in a year to allow proper treatment of mental disorders to be carried out to completion, including for those with severe and complex conditions who are able to benefit from active treatment or therapy.
5. Allow the use of both Clinical Psychology treatment services *and* Allied Mental Health Professionals’ Services for severe and complex cases.
6. Drop the need for a Mental Health Plan when referring to a Clinical Psychologist for treatment and use an ordinary referral letter, unless multiple services are considered necessary for the patient.
7. Call upon Clinical Psychologists to communicate with the referring practitioner concerning diagnosis, treatment and progress at specified intervals.
8. When assessing the costs of the changes, consider the reduction in physical health problems arising from untreated mental illness, the reduction in family breakdown due to untreated mental disorder, the reduced disability payments for those who recover from mental illness and the increased productivity of those who recover or improve substantially as a result of treatment for their mental illness. The benefits of shorter treatment needs for many should they suffer a recurrence of their mental disorder is a further eventual cost saving of these recommendations.
