5 August 2011

Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House Canberra
ACT 2600 Australia

Dear Senator,

Re: Government proposal to cut the 'Better Access to Mental Health Initiative' to 10 sessions.

I write to you as a Senior Clinical Psychologist of more than 14 years experience, who has worked across a number of sectors including the public psychiatric system, divisions of general practice, and private practice. I am writing to express my objection to two matters (1) The Government's proposed changes to the *Better Access to Mental Health Care Initiative* (*'Better Access Initiative'*) as announced in the 2011 Federal Budget, and (2) the Government's consideration of abolishing the current 'two-tiered' system of Medicare Rebates to psychologists. I will address each issue in turn.

(1) The Government is proposing a change to the *Better Access to Mental Health Care Initiative*, effective of November 1st 2011, that will see the yearly maximum allowance of sessions of psychological treatment available to people with a recognised mental health disorder reduced from 18 to 10 sessions.

(a) Not all clients attend for 18 sessions. Under current Medicare guidelines clients must attend their GP for review after every six sessions. At these reviews the GP, with consideration to recommendations from the psychologist, may approve further sessions if the client's condition warrants. I believe that this review is sufficient to ensure that only those clients who really require further sessions receive them.

For complex disorders, a strong body of scientific evidence demonstrates that clinical psychological intervention requires at least 12, and in some cases up to 30 or more, sessions for effective treatment of severe and complex psychological disorders. With the current state of psychological evidence, it's just not how it works. Therefore, those with the most severe or complex issues (e.g., those with complex obsessive-compulsive disorder, those with severe depression with suicidal features, those with complex personality issues) will be most disadvantaged, either financially, or worse, unable to continue with treatment. Clients with the most complex issues are often compromised because of their condition when it comes to attending work and therefore are the least able to fund their own treatment without assistance from Medicare.

(b) Requiring psychologists to deliver an outcome for complex clients within 10 sessions will place significant pressure on the psychologist and may result in the treatment being diluted for the client. Insufficient or incomplete treatment may mean that the client will need to start all over again with treatment at a later stage putting an unnecessary burden on government resources. Surely it is worth undertaking treatment properly and with integrity from the

outset.

(c) The decision to reduce sessions from 18 to 10 us based upon a Medicare evaluation with significant methodological flaws, which diminishes the credibility of the study. It has been reported that the study did not meet fundamental standards of research design (it did not identify the nature, diagnosis or complexity of the clients seen by psychologists by type of psychologist; it did not identify the nature or type of psychological intervention actually provided; it did not factor in or out medication use by the client; it did not factor in or out therapy adherence indicators; it did not have a valid criterion measure actually related to a range of diagnoses or complexity in order to assess pre and post intervention condition of clients; it did not undertake follow-up assessment of clients, which is often the point at which the relative strength of any competent treatment becomes manifest; it did not determine relapse rates by type of psychologist; it was a self-selected sample of psychologists who self-selected their clients and clinically administered the research questions in session; it was not subjected to peer review); and what is needed is a well-designed prospective study aimed clearly at answering specific questions in accordance with principles of psychological research.

(2) The current two-tier Medicare Funding for Psychologists. Relating to this second matter, I understand that there has been lobbying of the Government to abolish the two-tiered Medicare funding for psychologists (currently Clinical Psychologists are rebated by Medicare at a higher-rate than General Psychologists). I find this peculiar. Medicare is a body aimed at assisting those with clinical mental health issues, and not *all* psychologists are trained to do this (e.g., an Organisation Psychologist is not trained to treat Clinical psychological illness, and vice versa).

Regarding our specialisation, 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. We are well represented in high proportion amongst the innovators of evidence-based therapies, NH&MRC Panels, OYH/other mental health research bodies and within mental health clinical leadership positions.

Clinical Psychology is one of nine equal specialisations within Psychology. These areas of specialisation are internationally recognised, enshrined within Australian legislation, and are the basis for all industrial awards. They have been recognised since Western Australia commenced its Specialist Title Registration in 1965, and it is the West Australian model which formed the basis for the 2010 National Registration and Accreditation Scheme recognition of specialised Areas of Endorsement.

All specialisations require a minimum of eight years training including a further ACPAC accredited postgraduate training in the specialisation leading to an advanced body of psychological competency in that field. As is the case with Clinical Psychology currently, each area of specialisation deserves a specialist rebate with its own item number relating to that which is the specialist domain of that area of psychology (e.g., for clinical neuropsychology - neuroanatomy, neuropsychological disorders/assessment rehabilitation, etc; for health -

clinical health psychology, and health promotion). Specialist items for the other specialisations of psychology may mean that clinical psychologists might not qualify for any of those second tier items pertaining to other specialisations; however, we deeply respect specialisations within psychology and believe that our members would seek to undertake further training in those fields should they wish to seek to demonstrate that they have attained those other advanced specialised competencies that are not part of clinical psychology.

The proposed changes to Medicare Rebated sessions, and any downgrading of my specialist training qualification as a specialist Clinical Psychologist, would have far reaching implications for my private practice which is located in an under-resourced, lower socio-economic suburb in the North-Western suburbs of Melbourne. These include a diminished capacity to provide appropriate therapy to the most in need clients (moderate to severely disabled), and greater pressure on the local referring GP's who are already stretched to be able to provide services to their patients (North and Western Melbourne has a low GP to population ratio).

I find the suggestion that the proposed Medicare Locals (amalgamated divisions of general practice) will provide services to the more severe mental health clients through their ATAPS programs is extremely concerning and fraught. As a previous quality assurance officer at a division of general practice, I am more aware than most of the limitations of this approach to services. Most concerning is the lack of appropriate screening provided to referrals coming through such existing programs, which will now apparently be servicing the most severely unwell population. The significant short-fall in funding for the expansion of the ATAPS program (Tier III) will also leave an obvious major gap in service for those in most need. The idea that this program will somehow provide services for the most severely unwell clients, in place of an existing program that has been shown to be effective and is most appreciated by GP's and their patients alike, has left me baffled. The fact that these Medicare Locals are yet to be established in most areas (let alone the Tier III program of ATAPS funding they are meant to be administering), whilst the proposal to cut psychology session numbers through Medicare is due to occur under three months is nothing short of disgraceful. It would seem that the severely disabled clients requiring psychological assistance are destined to just have to do without, whilst the bureaucracy seeks to find a way for the proposed changes to occur. Nothing saddens me more that this fact.

Senator, I urge you to strongly reject these proposals immediately and instead maintain the current amount of treatment sessions available with a Clinical Psychologist under the *Better Access to Mental Health Care Initiative* to be 12, with an additional 6 sessions for 'exceptional circumstances'. I also urge you to retain the current two-tiered system of Medicare rebates for psychologists, which rightfully acknowledges and respects the additional, specialist training of Clinical Psychologists in assessing and treating mental health issues (an important function of Medicare).

I trust that my feedback will be given due consideration.

Yours sincerely,

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Clinical Psychologist

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