05 August 2008

Senator Claire Moore
Chair of Community Affairs Committee
P.O. Box 907
Fortitude Valley Post Shop
FORTITUDE VALLEY QLD 4006

Dear Senator

Re: Input on Sections 1.35-1.37 of the Interim Report on Mental Health, June 2008, noting increased access provisions of Medicare rebates for specified allied health consultations (pp. 8-9).

Submission by Henry Jackson MA (Clin Psych) PhD, FAPS; Raymond Rudd MSc (Clin Psych) MAPS

Due to our concerns with progress of the Better Access (BA) scheme, in particular the very large uptake in figures available up to the first quarter of 2008, the related large funding outlays, and limited data on cost-effectiveness, we felt a professional obligation to write at this stage. We wish to provide input from a clinical psychology viewpoint. We think this important, given the central role accorded to clinical psychology in BA, and the fact that this view has not been specifically communicated to the Committee since our submission and appearance at the first Inquiry (HJ/RR), Melbourne, 2005. Further details of our rationale are contained in the last section of this document. A number of specific, practical improvements for the BA scheme are recommended. Please provide copies of our document to Inquiry members as soon as practicable.

Yours faithfully

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Key points.

- We argue that the first trial of BA is fundamentally flawed, with its diverse mix of differing education and skills levels among those without postgraduate mental health training who are currently supplied provider numbers, and no evidence-based data regarding established professional competencies.

- The scheme requires basic restructuring from this current trial going forward, with a start date for a revised scheme that adequately differentiates the service functions of various providers according to their education and skills training.

- The only professionally and internationally recognised providers for mental health services with established evidence-based effectiveness are psychiatrists and clinical psychologists, both of whom have postgraduate education and training as specialists in clinical assessment, diagnosis and treatment. There is no substitute for such qualifications, such as "top-up" through short courses or other mechanisms by which individuals may seek to acquire membership of the particular specialist College. We are particularly concerned that clients with complex needs/multiple diagnoses will be poorly served by undertrained persons.

- Cost-effectiveness is a key factor. The logic of both clinical practice and cost-effectiveness requires the matching of service need to appropriate provider, as recognised in all adequate health service provision. This facilitates an adequate standard of service for taxpayer funds, including management of complex or risk-laden presentations. Professional ethical codes also require practitioners not to engage with clients when that practitioner's skills base is inadequate.

- Due to historically small professional numbers as a result of poor funding from the Federal Government previously for University places, and too few training places over a lengthy period, clinical psychology has remained within the larger umbrella professional and financial body, the APS. However, APS has chosen to speak in its submissions for all psychologists irrespective of members' possessing postgraduate education and training in mental health, or otherwise. Clinical psychologists thus do not have a sufficient independent voice nationally in relation to qualifications and standards of service in mental health matters, and the Inquiry. We contribute out of our personal concern for service adequacy, standards of professional practice, and duty of care to the public. We cannot and do not support the view expressed to the Inquiry that the majority of APS membership represents a large workforce that can provide specialised mental health services. Clinical psychologists comprise only 12% of the APS membership.

- A current existing shortfall in numbers of appropriate providers cannot be remedied in the short term, as with other health service areas, but only with more postgraduate trainees planned over an extended time frame. The prior government's initiative of extra places was helpful, but more are needed. Funding of clinical psychology is still inadequate despite a slight improvement over the last two years. In Australia, the per capita ratio of clinical psychologists to population is far less than comparable countries such as the UK and USA. Since the Inquiry in 2005, and in conjunction with the extra training places awarded by government in 2006, membership of the College of Clinical Psychologists has shown some increase from approximately 1200, to 2000 in 2008. This process needs to continue, and at a faster rate wherever possible.

- An information campaign needs to inform the community, and especially potential clients, of the professionally distinct and specialist educational standards and skills' competencies of postgraduate trained mental health professionals, in order that clients can make properly informed choices. This information is not available to any wide extent currently. The Department of Health and Ageing (DoHA) web site for BA also needs amending in this regard.

- A more comprehensive and professional evaluation methodology to be built into the restructured second round for BA, which allows for demonstration of value for taxpayer funding.

- A key recommendation of the Inquiry in 2006, that salaried positions nested within mental/health centres are the main vehicle for service delivery, should be implemented. This may require direct Federal funding, for which there are precedents, to assist in overcoming gaps in various states' mental health service structures and provision. In other fee for service situations, gap fees should be disallowed or strongly discouraged for low income or nil income clients in order to facilitate access. These strategies allow necessary cost containment (total spending is already approximately $280 million in a relatively brief period), as well as integrated and comprehensive case management. The latter is of high importance.

Main Issues.

Mental health disorder is a complex area and in local clinical practice and internationally this is recognised in identifying psychiatrists and clinical psychologists as the particular professionals required in providing adequate levels of care, management and treatment for mental health disorder. As noted at the Senate Inquiry Hearings, Melbourne July 2005 (HJ/RR), mental health core clinical services require the correct matching of service need to professional education and training of the service provider, as is standard clinical practice in all areas of health care.

Other training, particularly to any lesser extent, does not provide the range of skills needed. For example, we know from lengthy tertiary teaching and clinical supervision experience that a four year trained psychology graduate, although still legally registrable, simply does not have the required level of clinical skills in assessment, diagnosis and therapy. It is also now recognised that the current legal registration requirement is outdated and should be a postgraduate degree in whatever specialty, which is the accepted international practice. Attending brief courses for "top-up" or seeking other routes to acquiring membership of the relevant specialist College for mental health is in no way sufficient.

It is clinically illogical, as well as an important question of effective use of taxpayer funds, that BA core clinical services should be provided other than by the appropriate professionals, since the correct matching of service need to provider skill and training must take precedence. The primary service needs in the BA scheme comprise diagnosed mental health disorders. Such conditions need postgraduate level clinical skills in assessment and treatment. Client presentations may be serious conditions that can potentially involve life-threatening situations and other substantial clinical risk. The risks of client harm if skill does not match service need are considerable.

It is also accepted in professional ethical codes and in accordance with duty of care that a practitioner must re-refer when he/she does not possess the recognised professional training and experience. A more serious related difficulty can also occur when the poorly trained practitioner fails to re-refer because he/she does not recognise or know the particular other skills required for the presenting client. Whether this important consideration applies with the current scheme, and to what extent, requires closer attention in the review. Ethical considerations in relation to required skill competencies is also a significant factor in workforce planning, and underscores the need for the psychology profession to insist on postgraduate mental health qualifications in core services provision for the BA scheme.

Given the complexity of mental health, and the related ethical and competency responsibilities as well as risks, governments need to ensure that clients receive core clinical services from the appropriately qualified professionals. For example, client presentations under the scheme are not necessarily straightforward. It is common that individuals presenting with depression/anxiety also endure other comorbid and longer term mental health issues such as personality disorder, which renders the treatment situation far more complex or risk-laden. Research shows a rate of approximately 10% personality disorder in the adult population, with most more vulnerable for depression/anxiety conditions. From the important cost-effectiveness viewpoint, outcomes will be limited in more complex cases unless practitioners possess the necessary advanced, postgraduate level mental health skills.

In relation to formally demonstrated effectiveness in mental health assessment, diagnosis and treatment, the two postgraduate-trained professions noted previously are able to show researched, evidence-based information for a wide range, including complex, disorders. The same is not the case with other current BA scheme providers. For example, postgraduate- trained professionals possess the required skills to accurately diagnose personality disorder, and any associated risks. This level of clinical skill, obviously important, is not demonstrated readily by other current providers. The SANE Australia submission to the Inquiry (03.06.08) highlights the need for greater mental health services attention to personality disorder, in particular borderline.

Given the range of complexity in client presentations, it makes best sense to revise BA to a different and stepped care model that explicitly recognises these differences. The stepped care orientation makes most effective use of the workforce, and is not a feature of the current BA arrangements. For example, postgraduate level practitioners address the more complex presentations, and provide core services of formal psychotherapy and other specialist clinical inputs, such as assessment and diagnosis. The service inputs by non-postgraduate trained providers are best directed at less complex presenting problems, and any associated life context difficulties, which require basic counselling skills and not usually formal postgraduate trained psychotherapy, e.g., vocational or financial difficulty; poor problem-solving; lack of psychoeducation. This model also facilitates more comprehensive case management, with specialist clinical psychologists and psychiatrists having either joint management and/or a supervisory role.

A larger network for community mental/health centres, as recommended by the Inquiry Report (2006) is needed, with multidisciplinary teams including postgraduate trained mental health clinicians. Such teams allow for a comprehensive and integrated case approach, and arguably better risk management, especially where complex presentations are concerned. This best practice service structure is preferred to the fee for service model since the latter frequently cannot readily provide best practice comprehensive treatment, care and case management for at risk clients with complex presentations and/or serious mental illness.

The DoHA web site, MBS Allied Health Services (Item Descriptions, pp.35; 37-38), also highlights clearly the current significant unresolved discrepancies or mismatches between service need and service provider skills referred to above. It fails to specify the different training, skills’ assets and limitations of professionally distinct service providers, and this is unnecessarily confusing and professionally uninformative. In addition, there is no detailed information as to how MBS Items 80000-80020 for a specialist clinical psychologist, “psychological therapy”, stand in relation to the lower-funded other allied health Items, “focussed psychological strategies” (FPS: items 80100 etc.), for which providers do not possess comprehensive postgraduate level mental health education and training. The two sets of

Items need to be clearly distinguished, both for community information and to explain the higher scheduled fee for clinical psychologists.

The confusion is further compounded by the listings for non-clinical psychologists under FPS of "acceptable strategies" that includes, inappropriately, the term "cognitive behavioural therapy" (CBT). CBT in its proper professional definition is not the equivalent of counselling. The term CBT is currently used frequently too widely, loosely and incorrectly. CBT is a technical term that describes an effective research evidence-based treatment intervention for a wide range of disorder, and was developed in the main by clinical psychologists over the last thirty years. The proper practice of CBT requires a wide educational background in mental health theory, technical practice and research, which is only available from recognised courses at a postgraduate level. In like fashion, other psychological therapy interventions listed on the DoHA web site currently that require postgraduate training for effective educated application, ie. Interpersonal Therapy and Cognitive Therapy, are also listed inappropriately under FPS for allied health without relevant postgraduate level qualifications. These should not be taught without an existing foundation of psychopathology, assessment, diagnostics.

Overall, the web site information fundamentally confuses its list of "focussed psychological strategies" with formally trained psychotherapy. FPS's are limited, generally narrow technological approaches, which do not require the range, depth of knowledge and clinical training needed for adequate service delivery of formal psychotherapy. The two are quite distinct, as indicated above, by virtue of education and training background of provider. CBT, Interpersonal Therapy and Cognitive Therapy, for example, are not narrow and basic psychological strategies as are others listed, ie. relaxation; social skills training. A second major confusion is that, conversely, the web site information fails to note that clinical psychologists by virtue of their advanced training can also provide item numbers listed as FPS. These significant confusions have important practical cost-effectiveness implications, from the viewpoint of both clients and taxpayers, and require amending. Importantly, GP's engaged in mental health referral need greater clarity for matching service need to service provider.

MBS items 80000 and 80010 for clinical psychologists also refer to psychological assessment as well as psychotherapy (Item Descriptions, p.35). As with CBT, the knowledge and practice skills required for adequate clinical assessment and diagnosis in mental health is advanced and complex, and there is a large number of assessment tools to consider, as well as keeping abreast of recent professional developments. Practitioners without postgraduate mental health training are unlikely to possess those advanced skills in mental health assessment or diagnosis. The current title of MBS Items 80000-80010, "psychological therapy", needs amending to more accurately reflect these key clinical psychology functions.

At a broad level, if the primary emphasis in start-up of BA was on a maximum number of providers and a large throughput as an index of success, that view was inappropriate in relation to basic clinical principles and practice logic, and international best practice standards. We need to accept that ready access nationally to clinical psychology and psychiatry services in the scheme cannot be achieved in the short term. Further, the historical per capita ratio of clinical psychologists to population is low in Australia compared to the UK and USA. This fact was recognised by the prior government's awarding of a thousand extra tertiary training places over five years and by 2008 there has been some progress, with the membership of the College of Clinical Psychologists now approximately 2000, compared to only 1200 in 2005. We now need a longer term plan than five years, and ongoing review of the adequacy of the extra training places referred to above. In many health service areas, e.g., GP's, it is also not possible to provide the extent of coverage required nationally, except perhaps over a longer time period.

The review of BA needs to consider restructuring to a scheme with better and more explicit matching of provider skills to service needs, and a more thorough evaluation methodology. We understand there is little in the way of adequate evaluation data yet available. The professionally required evaluation is a comprehensive methodology that employs more than the one tool. For example, use of both pre/post treatment evaluations via objective scales; a similar longer term follow-up; and, other measures as required, such as structured interview, are all indicated. Only a more comprehensive evaluation than that currently in BA can provide satisfactory cost-effectiveness data. For example, the nature of the material contained in sample surveying of client "satisfaction", which has been submitted, is inadequate for the overall purpose in both scope and method.

Recommendations

We urge the Inquiry to consider recommending restructuring of the Better Access scheme as follows.

1. Salaried positions within existing or newly created community-based mental/health teams as the primary vehicle for service delivery, allowing for better integrated case management, cost containment, and back-up for clinical consultation or client risk management. To elaborate, in our view this should be especially the case for clients at risk and with complex presentations and/or serious mental illness. The clear precedent is direct Federal funding of local and regional services. In fee for service situations, there should be no gap fees, but a cap at the scheduled amount for those who have no or limited income.

2. Implement a stepped care model for Better Access, which acknowledges the wide range of complexity in client presentations, and thus specifies more accurately the different skills and services of providers within the scheme.

3. Revise DoHA web site details for MBS, Allied Health Services, Part 4, pp. 37-38 to more accurately specify those functions for which non-clinical psychologists are qualified, currently listed as “focussed psychological strategies”. This requires amendments to Section 3, p.37, point 2: delete “Cognitive- behavioural Therapy”, “behaviour modification; exposure techniques”; “cognitive interventions-cognitive therapy”. Substitute “Behavioural interventions, e.g., activity scheduling”. For point 5, delete “Interpersonal Therapy”.

4. Alter the title of MBS Items 80000-80010 to “clinical psychological assessment, diagnosis and therapy” for accuracy; and, provide written elaboration in the DoHA web site BA section of those functions for which clinical psychology has the recognised professional mental health training. The education and training requirements for adequate provision of CBT, as it is professionally defined and recognised, and described previously, is a key case in point. Providing GP’s and GP Divisions with fliers giving sufficient information regarding the training and competencies that make mental health specialist professionals distinct is indicated, as well as for the overall community, so that better individual decisions with assistance if required can ensue.

5. Provide clinical psychologists with rights to conduct all aspects of intake assessment, including diagnosis; and, for salaried individuals to receive direct referrals, where no over-servicing can ensue. Just as their broad knowledge and supervised training background underpin practice of CBT, clinical psychologists are also specifically trained in psychopathology and the specialist functions of diagnosis and clinical management.

6. In the context of assuring adequate ongoing education and training, it is important to communicate to national bodies on tertiary training standards, e.g., Australian Psychology Accreditation Council, that the requirements for professional mental health service providers need to remain at the postgraduate level described previously in this submission. Particularly in mental health, which has been poorly serviced for a lengthy period, the need to retain and further promote appropriate training standards and attract a larger workforce is paramount. For those currently engaged with BA and upgrading of their skills to the nearest equivalent of recognised postgraduate training, a transition period with a clear end date is needed. Short courses or other mechanisms for “top-up” are not a substitute for thorough training. Those are only useful as further professional education in mental health, following postgraduate degree.

7. Review of the adequacy of numbers of government-supported tertiary training places in clinical psychology over more than the current five year plan, especially in relation to rural/remote areas which are poorly serviced by psychiatrists and clinical psychologists; and, the adequacy of any take-up incentives. The latter is important. For example, the Federal Government is currently examining the adequacy of incentives for teaching recruitment, and

extra financial reward for remaining in under-serviced areas over a specified period.

8. Implement a strategy for private providers not to exceed the scheduled fee for those with limited or no income, in the interests of promoting wider and more ready access, which is a key goal of the mental health Inquiries. Ironically, the current BA 30% lower fee per hour for non-clinical psychologists may possibly act as an incentive for charging a gap fee more frequently.

9. Implementation of comprehensive, ongoing professional evaluation mechanisms, as described prior, for sufficient sample sizes of service clients.

10. There be no reduction in spending allocation such that the scheme may be forced to consider paying for a lesser trained workforce generally, in addition to realigning service needs with appropriate professional service providers in BA, as detailed previously. We understand there have already been some indications that the new national professional accreditation procedures may allow some standards of training to be weakened.

Context and rationale.

Following submission and presentation at the first Inquiry (Melbourne, July 2005, HJ/RR) and having been concerned as are many other colleagues with the initial Better Access scheme, we felt obligated as senior clinical psychology professionals committed to standards of service provision and duty of care to write to the Inquiry directly at this point in time.

Our communication is aimed at providing informed, independent comment and practical suggestions, unfettered by any other consideration apart from client service quality, and responsibility to the Australian community at large. At this point in time neither of us have sought to take up access to BA so we are not seeking any personal fiscal advantage. Nor are we seeking to "promote" clinical psychology vis a vis any other profession, e.g., psychiatry. Our only concern is with adequate service qualifications and standards for adequate service provision, and observing duty of care and the professional ethical codes that accompany it.

An independent voice for clinical psychology is currently constrained, as follows. Just as the Royal Australian and New Zealand College of Psychiatry (RANZCP) is the specialist College body for psychiatry, the College of Clinical Psychology is the sole recognised body representing clinical psychologists in Australia. However, unlike RANZCP, and due to historically small numbers, clinical psychology does not have an autonomous and separate professional body that speaks solely on its behalf, but is located within the broader structure of the APS, which represents all psychologists regardless of specialist training or otherwise. In our experience and that of other senior colleagues the current structure has caused tension over a long period of

time, certainly over the best part of 20 years. Whilst we believe the APS is an important body for psychologists and representing psychology-related matters in general, we believe it can not fairly represent our views in clinical mental health professional matters. This is now even more important with the advent of Medicare rebates for non-medical service provision, and the need for considerable taxpayer funding. We were concerned that an informed view and specific suggestions from a clinical psychology perspective be provided.