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

1st August 2011

Dear Senate Standing Committee,

Thank you for establishing this Inquiry into the Commonwealth funding and administration of mental health services and for the excellent Terms of Reference. The enclosed submission provides information and recommendations addressing most of the Terms of Reference for your consideration.

The Australian College of Specialist Psychologists (ACSP) is a newly formed national College. Its membership is open to post graduate university trained and supervised specialist psychologists, from any of the nine speciality areas in psychology (Child and Developmental, Clinical, Clinical Neuropsychology, Community, Counselling, Forensic, Health, Organisational and Sport). One of the central principles of the College is the support the requirement of post graduate training and supervision as the pathway into professional practice in psychology, and this is a theme throughout the submission. High levels of training and skill are essential for the protection of the public, especially in mental health care where the child, adolescent or adult is very emotionally vulnerable. Supporting post graduate training and supervision is also essential as it will allow the psychology profession in Australia to gradually move towards international training standards, which we currently do not meet. The ACSP also promotes the need for Australia to have a highly skilled and trained workforce into the future, and we hope that the decisions made by the Senate Inquiry will enhance and encourage this direction in mental health care.

While the current Terms of Reference are focusing on mental health services, the ramifications for all sections of psychology with regards to standards of training are evident.

The ACSP welcomes the Senate Inquiry and sincerely hopes that some positive changes in mental health service provision in Australia will flow from its findings. Please find the ACSP submission to the Inquiry in the following document.

Yours sincerely,

Dr. Jillian Horton
President of the Australian College of Specialist Psychologists

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Summary of the Australian College of Specialist Psychologists Recommendations

(a) The Government's 2011-12 Budget changes relating to mental health

ACSP Recommendations

1. Cost savings need to be considered within a wider perspective to take into account the money saved when good psychological outcomes are achieved.
2. If cost savings need to be achieved, in terms of money spent in the Better access scheme, then it must be done in ways which do not negatively affect the integrity and outcomes of psychological therapies.

(b) Changes to the Better Access Initiative
(i) The rationalisation of general practitioner (GP) mental health services

ACSP Recommendations

1. Delete the requirement that a GP (or other medical specialist) has to make a referral to specialist psychologists in the Better Access initiative.
2. Delete the requirement of a GP review during the psychological therapy process.
3. Have the pre-budget level of rebate paid to GPs who choose make a referral to a specialist psychologist using a mental health care plan.
4. Have specialist psychologists manage the referral process to people providing "focused psychological therapies".

(iv) The impact of changes to the number of allied mental health treatment services for patients with *mild or moderate* mental illness under the Medicare Benefits Schedule

ACSP Recommendations

1. That the current definition and understanding of the Better Access initiative as mostly providing services to people with mild to moderate mental health problems be corrected, to be in keeping with the evidence showing that the majority of people treated within this initiative had moderate to severe levels of distress and psychological disturbance.
2. For the language which describes levels of distress or disability of a diagnosed patient ("mild, moderate and severe"), not be used by Governments to make decisions about psychotherapy options, length of psychological therapy, or the skills and training levels required by the practitioner.

3. That the length of psychological therapy required by individuals be guided by research evidence, and be decided by the treating clinician, not by economic policies.
4. That the number of Medicare supported sessions to specialist Psychologists not be reduced.
5. That the Government consider increasing the number of Medicare supported sessions to specialist psychologists to undertake non-drug psychological therapies, so that it is equitable with current Medicare funded psychiatry services.

(c) The impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program

ACSP Recommendations

1. That the Federal Government base its funding decisions for the ATAPs program on the findings and suggestions in the ATAPs review. That is, to have this program be a complementary program to the Better Access initiative, by retargeting its services towards rural and regional areas, with a focus on low socioeconomic and Indigenous people.
2. That it is a requirement for the ATAPs program to employ or contract appropriately trained professionals (specialist psychologists) to do the psychological therapy with people who are diagnosed with psychological disorders.
3. For the Government to ensure that the pay rates are commensurate with the training levels and skills of the providers so that appropriate providers are attracted to the scheme.

(d) Services available for people with severe mental illness and the co-ordination of those services

ACSP Recommendations

1. State Governments be required to increase funding to state public community mental health services.
2. Federal funding be used to assist in the establishment of public housing and employment programs specifically targeting people with high disability mental illnesses.
3. State Mental Health Commissions act as a research and co-ordinating body for funding allocation and service provision within each state.

(e) Mental health workforce issues, including:
(i) The two-tiered Medicare rebate system for psychologists

ACSP Recommendations

1. In the short-term, to maintain the two tier rebate system as it is.
2. Having specialist psychologists managing the referral process to people providing "focused psychological therapies".
3. Provide educational programs to assist GPs and community members to understand the difference between these two service levels.
4. In the longer term, to gradually phase out "focused psychological therapy" services, as more post graduate providers become available.

(ii) Training of psychologists

ACSP Recommendations

1. To phase out of the undergraduate degree (apprenticeship model) as a pathway to registration for professional practice.
2. To require a minimum of a masters degree and 2 years supervision in psychology for registration to professionally practice in psychology.
3. To establish specialist registration in 2013 for the nine speciality areas in psychology under the National Registration Scheme.

(ii) Workforce qualifications

ACSP Recommendations

1. Supporting an educational campaign for workplaces and the public about what the difference between general supportive counselling and psychological therapy is.
2. Educate workplaces and the general public about the level of training and skill needed to undertake these two different forms of work.
3. Monitor the training and skills level of people employed in state government departments and other government funded bodies, to ensure the maximum protection of the public.
4. Creating a climate of understanding that mental health problems are complex and require proper care and treatment.

(iii) Workforce shortages

ACSP Recommendations

1. Promoting and supporting more post-graduate university training places in psychology for Australian students.
2. Wavering/subsidising psychology post-graduate fees.
3. Providing more funding to psychology university departments to employ more people to train post graduate students.
4. Increasing the number of positions for specialist psychologists in public mental health care workplaces so they can provide the professional supervision to psychology post graduate registrars.
5. Providing financial incentives and career structures in public workplaces to encourage more specialists to work in community based services and to undertake post-graduate training.
6. Increasing the mental health workforce in the private sector by expanding Medicare to include not only clinical psychologists but also other post graduate trained mental health specialists (child and developmental psychologists, clinical neuropsychologists, counselling psychologists, forensic psychologists and health psychologists).
7. Establishing specialist registration for the profession of psychology in 2013.

(g) The delivery of a national mental health commission

ACSP Recommendations

1. Every State in Australia to establish a Mental Health Commission (MHC).
2. MHCs be responsible for researching the mental health needs of their State.
3. MHCs establish what funding levels are required for mental health care in different sections of their State and have a co-ordinating role in funding distribution.
4. MHCs support and promote the proper work conditions and ratios of professionals being employed in sectors receiving state and federal funding.
5. MHCs have a good mix of professionals who provide a range of mental health care services, on boards and advisory panels, including people from academic and clinical positions.
6. MHCs having a range of specialists as Chairs of advisory boards and panels, rather than typically having a medical specialist heading the Commission or advisory group.

(h) The impact of online services for people with a mental illness, with particular regard to those living in rural and remote locations and other hard to reach groups

ACSP Recommendations

1. In the short to medium term, Government funding for fly-in fly-out psychological services.
2. Online face to face therapy services, with additional telephone link ups, being the minimum requirement for government funded online services.
3. Providing travel allowances, and Medicare support for extended therapy services (double sessions) with specialist psychologists, if a person travels a long distance to obtain services.

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Terms of Reference: The Government's funding and administration of mental health services in Australia

(a) The Government's 2011-12 Budget changes relating to mental health

When the Better Access initiative was introduced in 2006 under the Howard Government, the scheme was seen as a major achievement in providing community based psychological services to a very large sector of people with moderate to severe psychological disorders. The Medicare funded services have been highly utilised by the community and was the first time community members had real possibilities to access evidence based, non-drug therapies. To quote a section from the Government funded Better Access Review, which was released in April 2011,

"The Post Implementation Review found that the Better Access initiative has significantly increased access to affordable mental health services in the primary care sector and to many patients who previously could not afford these services, thereby meeting a previously unmet need...... This major mental health reform seems to have improved access to and outcomes from primary mental health care for people with *<u>moderate to severe</u>* *common mental disorders...... The MBS is the most effective and efficient means of providing this servi**ce."*** (emphasis added)

The Australian Psychology Society (APS) review of the Better Access initiative supported these comments when they found from their survey that 72 per cent of clients referred under the Better Access initiative had never seen a psychologist before. It was also reported that 73 per cent of clients could not have accessed psychological services without the Medicare rebate being available.

The Better Access review further found that the cost for treatment of the high prevalent disorders (depression and/or anxiety) was on average $753.31 per person. Previous work had estimated that optimal treatment for these disorders would cost about $1,100 (in 2010 dollars). The Review concluded that on the basis of these figures, Better Access provides good value for money in terms of MBS costs to Government.

It is clear that cost savings and management of the mental health budget are some of the major drivers of change in the Federal budget. However, if the Government is concerned about the fiscal aspects of mental health care, it needs to also think more widely about the cost savings it makes when people are properly treated and recover from mental health problems. While no data was obtained in the review about these costs savings it would be reasonable to conclude that changes such as an increase in work productivity, less sick leave taken, and a reduced need for more intensive and expensive services such as hospital care and other medical treatments, would represent significant savings to Government. A much wider perspective is required before any changes should be considered, especially to a program which has been found to be cost effective and efficient.

(b) Changes to the Better Access Initiative

(i) The rationalisation of general practitioner (GP) mental health services
It is understandable that the Government may wish to explore ways to reduce the costs of GP referrals and reviews, given that Medicare statistics shows that nearly 40% of the Better Access budget is spent on these administrative processes. Specifically, during 2006-2008 the preparation of GP Mental Health Care Plans (MHCP) costed the Federal Government 135.7 million dollars. The MHCP reviews costed 23.6 million dollars. The Better Access review also found that a high percentage of people who had a MHCP written, did not follow through with mental health services subsequently. This percentage was even higher as the patients' location became more rural and remote. Specifically, of the urban patients who received a MHCP during 2007, **33.8 per cent** did not receive follow up MBS mental health services in the immediate subsequent 12 months, and **37.7 %** of patients in rural and **48.9%** in remote locations did not receive MBS mental health services. This indicates that a significant number of MHCP billed to the Government were of no value, or at the very least were not utilised.

However, reducing costs in this part of the initiative needs to be considered carefully as it needs to be undertaken in a way which does not negatively impact the motivation of GPs to refer their patients for psychological assistance. It has already been reported in the Medical Observer magazine (July 2011) that more than one in four GPs will stop drawing up mental health plans for patients if the Federal Government goes ahead with plans to reduce the associated Medicare rebate. This was found in an AMA survey of more than 700 GPs and was announced by the AMA president Dr Steve Hamilton during his address to the National Press Club.

A more positive option would be to remove the mandated requirement for a GP to make a referral to a specialist Psychologist (post-graduate trained Clinical and Counselling Psychologists). Then those GPs who wish to continue to make referrals using the MHCP, could continue to get the pre-budget level of rebate. As suggested succinctly by a GP "*Simple solution, break the nexus between MHCPs and psychologist referrals! Allow me to refer patients for psychology services under Medicare in the same way as I do to specialists and I will have claimed my last item 2710. The MHCP process is a cumbersome waste of time and when I manage mental health issues without psychologist help I use the content based item numbers quite happily. Getting my distressed, disturbed patients to waste time filling out K10s and wait while I fill out a meaningless proforma plan to give them is absurd. Minister Roxon, leave the rebate at its present level for the few GPs who like using the plan format. Allowing the rest of us to refer more simply means most of us will never touch it (MHCPs) again, saving you millions. Problem solved.* "

There is a precedent set for open access to specialist psychologists in the private health insurance industry. For example the biggest health insurer in WA (HBF), does not require GP referrals to specialist psychologists in order for their customers to claim rebates. Such changes would also assist those people who do not wish to discuss their mental health

concerns with a GP and reduce the burden on overloaded GP appointments, which can at times be difficult to obtain for medical treatment.

Another positive option would be to remove the required GP review process of specialist psychology services. GPs do not do this sort of mandated review of therapy and re-referral with any other specialist in the Medicare system. Therefore it is unclear what the underlying rationale is for GPs having to bear the load of this additional work in relation to specialist psychology services. It also unnecessarily increases costs to patients and the Medicare system. The ACSP supports unequivocally the need for communication between professional groups, however this process is time consuming and expensive, and it is unclear how useful it is in its current form. A second issue in relation to GPs reviewing specialist psychology treatments is that very few GPs have sufficient training to be considered competent to review psychological treatment.

An third more flexible and cost saving arrangement would be to make specialist psychologists, rather than GPs, responsible for referrals to people providing "focused psychological therapies". Specialist Psychologists are thoroughly trained in their post graduate programs to assess and diagnose mental health disorders and to decide what therapy options are required for effective treatment. They would arguably be in a better position than GPs to decide when a person would benefit from focused skills training versus individualised psychotherapy interventions.

ACSP Recommendations

1. Delete the requirement that a GP (or other medical specialist) has to make a referral to specialist psychologists in the Better Access initiative.
2. Delete the requirement of a GP review during the psychological therapy process.
3. Have the pre-budget level of rebate for GPs who choose make a referral to a specialist psychologist using a mental health care plan.
4. Have specialist psychologists manage the referral process to people providing "focused psychological therapies".

(iv) The impact of changes to the number of allied mental health treatment services for patients with *mild or moderate* mental illness under the Medicare Benefits Schedule

Firstly, it needs to be disputed that the Better Access scheme mostly services people with mild to moderate mental health problems. The Better Access review data and other independent reviews clearly showed that specialist psychologists were being referred, and were treating, people with moderate to severe levels of distress and psychological disturbance. For example, the Better Access review found that more than 90% of people using psychological services met the criteria for a formal diagnosis of depression and/or anxiety. This compares with 13% of the general population. Around 80% of these patients reported high or very high levels of psychological distress, as assessed by a GP given questionnaire at referral point. This compares with 10% of the general population. The APS

research of the Better Access initiative found **over 80%** of patients were reported as presenting with moderate to severe levels of symptom severity. A smaller number of people (less than 20%) presented with milder symptoms, but these were still sufficient to meet diagnosis and need referral for treatment.

The ACSP would like to secondly comment on the confusing and often problematic grading of symptoms and/or mental health problems into categories of “mild, moderate and severe”. It is often unclear how the terms “mild, moderate and severe” are actually being used. If these terms are being used to separate out *mental illnesses* such schizophrenia or bipolar disorder from the high prevalence *psychological disorders* such as depression and anxiety, they may have some limited use. That is, people who suffer with mental illnesses often require more comprehensive care such as medical and nursing interventions, hospitalisation as part of their treatment and they may also need broader services such as community housing and employment support. This reflects the high level of disability experienced by people with these mental illnesses. The majority of people who have diagnosed psychological disorders however, do not need these extended and more comprehensive medical and community services. Therefore, if the terms are used to help distinguish between the level of disability and hence the sort of services required, then they have some use.

However, when the terms “mild, moderate and severe” are being used to categorize symptoms or disability within a specific diagnosed disorder, then they are not helpful and actually become very problematic. This is because all mental health problems, if they are at the level of requiring professional treatment, are complex, and have a history of psychological and relationship factors attached to them. Level of distress or disturbance should not be used as a rationalisation for determining the levels of expertise or training in the practitioner or how many psychotherapy sessions will be supported by Medicare. If a person seeing a specialist psychologist has comparatively less distress or less disturbance from another person being treated by a specialist, the former person will be treated more quickly and recover more quickly than the latter.

The ACSP is very concerned about the impact the reduction of supported therapy services will have on patient outcomes. When examining therapy length, research evidence shows that reliable recovery, with low relapse rates, requires more than 6-10 sessions of psychological therapy. An Australian study by Harnett, O'Donovan & Lambert (2010) aimed to estimate the number of sessions of psychotherapy needed for clients suffering from mostly depression, anxiety, or adjustment disorders, to return to a normal state of functioning, and for this to be reliable improvement. The progress of 125 clients entering psychological treatment in two university post graduate training clinics was tracked on a session-by-session basis. Recovery and reliable improvement were outcomes used to estimate the number of weekly, one hour treatment sessions needed, to meet criteria. It was found that it would take about 8 sessions for 50% of clients to show reliable improvement, and **21 sessions** for about 85% to meet this criterion. Recovery however, took more treatment, with 50% of clients estimated to recover after 14 sessions and 70% requiring **23 sessions**. The authors concluded that:

"On the basis of the present results we conclude that the present policy of the Australian Government in both the public and private sector, regarding the number of sessions needed for clients entering psychological treatments to show a benefit, is much less than is necessary. The current (Government) policy appears to be suitable for only about one-third of clients who carry the burden of psychological illness."

Another study conducted by the National Institute of Mental Health involving 250 clients who had received 16 sessions of psychological therapy, found that both Cognitive Behaviour therapy and Interpersonal therapy worked equally effectively over the same period of time for major depressive disorder in comparison to medication (SSRI's). However, follow-up data of the people involved in the study found that around 33% of the sample relapsed within 18 months. The chief researchers who headed up the study stated:

"The major finding of this study is that 16 weeks of these specific forms of treatment is insufficient for most patients to achieve full recovery and lasting remission."

The findings of these studies are consistent with other research and suggest that approximately 20 to 25 sessions are needed for the majority of people to recover from the high prevalence mental health disorders. It could certainly be viewed as cost inefficient and unethical to fund a treatment process which does not adequately treat the majority of people using the service.

One rationalisation the Government is using to cut the number of psychological therapy sessions is from findings in the Better Access Review, that during 2007 and 2008 most patients (nearly 74 per cent) accessing Better Access mental health items only claimed between 1 to 6 services. However, the reviewers of the initiative state:

"this low claiming rate could be attributed, in part, to patients who have commenced a mental health care plan towards the end of the calendar year and have not claimed many subsequent services within that calendar year".

The APS review found 47% of clients were reported to access services beyond 10 sessions of treatment and over 60% of clients needed more than 6 sessions, which is in contrast to the Better Access findings. There were no recommendations in the Review for the number of sessions to mental health therapy to be cut.

It is very problematic to base such major funding decisions on such limited information as number of sessions utilised. It is surely an ethical requirement that the length of psychological treatment should be decided by the treating specialist, like it is in any other health care area. This is especially important in mental health care, as it takes time to build trust and a working relationship with someone so that intimate life details and concerns can be discussed. For a Government to interfere with and micro-manage such important clinical decisions, also potentially opens them to litigation, if peoples psychological conditions are not properly treated in the time frame the Government has decided is sufficient.

A further issue regarding funding of mental health services is the lack of equity in Medicare support for psychiatry services and psychology services. Although there is a clear demand for psychological therapies in the initiative, Medicare support for a patient to see a psychiatrist has remained at 50 sessions per year, at a higher cost to Government (approx. $350 per session), compared with the proposed 6-10 sessions with a specialist psychologist (approx. $119 per session). Given that specialist psychologists are trained specifically in the provision of non-drug psychological therapies, this inequity of support for patients to access the different treatments is difficult to justify. Another option would be to increase the choice for consumers by providing equal access to psychiatry and specialist psychology services.

Finally, an interesting comparison between the definitions of "short term" psychological therapy used by the Australian Government, with another country which financially supports psychological therapy is worth examining. The German Government and insurers since 2000 for example, provide full rebates for Clinical Psychology services for 25 sessions, which is defined as short term therapy, and for 45 sessions which is defined as standard long term therapy and payments can to be extended by 15 sessions to a total of 60 sessions. They do not fund psychologists who only have undergraduate training. This puts the Australian Governments investment into a different perspective.

ACSP Recommendations

1. That the current definition and understanding of the Better Access initiative as mostly providing services to people with mild to moderate mental health problems be corrected, to be in keeping with the evidence showing that the majority of people treated within this initiative had moderate to severe levels of distress and psychological disturbance.
2. For the language which describes levels of distress or disability of a diagnosed patient ("mild, moderate and severe"), not be used by Governments to make decisions about psychotherapy options, length of psychological therapy, or the skills and training levels required by the practitioner.
3. That the length of psychological therapy required by individuals be guided by research evidence, and be decided by the treating clinician, not by economic policies.
4. That the number of Medicare supported sessions to specialist Psychologists not be reduced.
5. That the Government consider increasing the number of Medicare supported sessions to specialist psychologists to undertake non-drug psychological therapies, so that it is equitable with current Medicare funded psychiatry services.

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(c) The impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program

The Access to Allied Psychological Services (ATAPS) program funded through the Divisions of General Practice under the Better Outcomes in Mental Health program, was established prior to the Better Access initiative. The ATAPs program was originally viewed by the Government as complementary to the Better Access initiative, as the latter program was able to reach many more people. The ATAPs program had been planned to be retargeted towards rural and regional areas, with a particular focus on low socioeconomic and Indigenous people before the Budget announcement. However the ATAPs program will now receive an increase in capped funding, at the expense of the Better Access initiative, even though the ATAPs review (2009) clearly indicated it did not have the scope to replace or compete with the Better Access initiative. To quote from the review:

"One of the most significant initiatives in the COAG package, and with most relevance to ATAPS, was the commencement in November 2006 of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative (Better Access). Under Better Access, psychiatrists, GPs and psychologists are able to provide mental health services on a fee-for-service basis subsidised through Medicare. These services parallel the original program design of ATAPS, offering access to short term psychological therapies but provided through private providers, rather than through fund-holding arrangements."

"It is an important and necessary program to complement the Better Access Initiative. ATAPS and Better Access are operating in a complementary fashion to meet the mental health service needs of Australians."

"In the consultation process there was strong support for a continuing role for ATAPS as a capped program with finite resources in targeting people with mental illness who have a need for short term interventions. <u>There was recognition that the reach of the program would be diluted if the program was extended to the broader population</u>, "

and

<u>"It makes sense that ATAPS, with its defined budget, is an adjunct to Better Access. That is, that Better Access remains the service to provide the majority of mental health services to the broader population and that ATAPS operates in a complementary manner to provide mental health services to those consumers who do not or cannot access Better Access services</u>."

It appears the Federal Government has once again ignored its own findings and has now shifted significant funding into the ATAPS program by reducing funding to the successful Better Access program. If the additional funding is used specifically to provide extra services which the Better Access initiative cannot provide, then the Government needs to consider expanding its commitment to mental health, rather than robbing one program to pay for

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another. Even more concerning is that the administrative bodies (Medicare Locals) have not been fully established, so many people may not be able to access services for some time. Medicare Locals are also reportedly to be administered by independent Boards of Management, with as yet no clarity as to whether there will be anyone on the Boards with expertise or knowledge in mental health. Therefore it is of major concern as to what level of funding will actually go into mental health services, what level of training and skill psychological service providers will be required to have, and what work/pay conditions will be offered to psychological service providers. The latter two factors will significantly affect the sort of providers which will be attracted to work in the scheme, having then a direct effect on the quality of care offered to the public. These same concerns apply to other administrative bodies that the Government may fund, including NGOs.

These concerns are not without basis as the ATAPs reviewers makes the following comments:

"While quality control of the services provided is an important issue, setting the competencies and professional qualifications of providers at too high a level could reduce significantly the available workforce to provide services, and reduce service access particularly in rural areas. The emphasis should be on capacity to provide a service."

and

"Under ATAPS – with a capped budget – it is understandable that Divisions may be attracted to recruiting allied mental health providers who attract a lower salary and thus the available funding to stretch to provide a greater number of services."

and

"The quality of the mental health services provided under the ATAPS initiative varies enormously between providers and Divisions. What it does indicate is varying quality around the availability and recruitment of providers, differing levels of experience and qualifications of providers and even the skills and experience of the staff who administer ATAPS within Divisions."

These findings and comments are of major concern. The Australian community should have the highest and most skilled practitioners treating them, and this should not be jeopardized by funding or administrative cost saving measures. There are no guarantees these issues have been addressed and in the current climate of economic rationalisation, the "quantity over quality" argument may lead to significant negative outcomes for vulnerable children, adolescents and adults.

ACSP Recommendations

1. That the Federal Government base its funding decisions for the ATAPs program on the findings and suggestions in the ATAPs review. That is, to have this program be a complementary program to the Better Access initiative, by retargeting its services

towards rural and regional areas, with a focus on low socioeconomic and Indigenous people.
2. That it is a requirement for the ATAPs program to employ or contract appropriately trained professionals to do the psychological therapy with people who are diagnosed with psychological disorders.
3. For the Government to ensure that the pay rates are commensurate with the training levels and skills of the providers.

(d) Services available for people with severe mental illness and the coordination of those services

If by "severe" it means those people with mental illnesses who require more comprehensive services, then clearly the Governments proposed focus on housing, workplace support, and expanding community based public services, is essential. Public mental health services have an advantage over private services in that they have multi-disciplinary teams available to cater for the varying needs of those affected. Community nursing is an essential feature of this community care, to monitor medical and emotional needs and to facilitate hospital or psychological treatment as needed. However the State public mental health services have been starved of funds for many years and although there has been widespread condemnation of the adequacy of these services, it is very unclear whether the problem is inadequacy of the type of service, or whether it has been insufficient funding.

With the growing move towards each State having a Mental Health Commission, it would make sense that these Commissions have some co-ordinating input into funding distribution and the type of services to be supported and developed in particular catchment areas.

ACSP Recommendations

1. State Governments be required to increase funding to state public community mental health services.
2. Federal funding be used to assist in the establishment of public housing and employment programs specifically targeting people with high disability mental illnesses.
3. State Mental Health Commissions act as a research and co-ordinating body for funding allocation and service provision within each state.

(e) Mental health workforce issues, including:

(i) The two-tiered Medicare rebate system for psychologists

In 2005 the Federal Government conducted a Senate Inquiry into mental health after considerable community and professional concern had been raised about the lack of mental health services available and the major suffering people were experiencing as a result. A major report was written and one of the recommendations from this report was for Medicare

items to be made available for people to access private psychological services. This was deemed necessary because the existing Better Outcomes in Mental Health initiative, which also provided psychological services under the ATAPs scheme, was not reaching enough people. As stated in the ATAPs review:

"The introduction of Better Access provided an alternative service pathway for consumers experiencing mental illness who had previously relied on ATAPS services. In fact, due to the nature of Medicare based funding, the Better Access program provided greater access to services due to a significantly larger (consumer referral driven) program budget. Better Access operates very successfully in the majority of communities and geographic areas as a universal program aimed at improving access to treatment for high prevalence disorders".

It is unclear how the two tier component of the Better Access initiative was developed, as it was indicated by the Chair of the 2005 enquiry (former leader of the Democrats Lynn Alison), that only specialist (Clinical) psychologists were preferred for providing services via Medicare. She did indicate however, that the Australian Psychological Society (APS), and possibly others, recommended that services should also be provided by undergraduate psychologists. (It needs to be noted that the membership of the APS consists of over 75% of undergraduate trained psychologists). The problem of workforce numbers was no doubt also an issue, and this continues to be a major tension between quality and quantity of service in mental health care.

Undergraduate psychologists in the Better Access initiative (plus social workers and occupational therapists) were restricted to provide "focused psychological therapies", originally meaning the provision of skills based learning to patients. Specialists were to provide the individually tailored psychotherapy interventions, focusing not only the symptoms but also the causes of the disorders. However the ability of the referrers in the initiative, to define and separate out the needs of patients has proven to be very problematic. As mentioned previously, many GPs did not (and still do not) know the difference in the training or skills between psychologists, social workers and OTs, as compared with specialist psychologists, and hence it is difficult for them to determine what services are best suited to the needs of their patients.

Another major problem is the underlying concept which suggests that two different layers of services are useful and appropriate, as it makes an artificial separation of skills learning from the deeper psychotherapy interventions. These components of therapy work together and any patient whose symptom severity reaches a mental health diagnosis, needs to be treated by a skilled professional who is trained to work with all levels of the patients needs.

Decisions about the capacity of a practitioner to provide psychological therapies should be based on their training and expertise, as is the case in all other health areas. As outlined more fully in the next section, post graduate training and supervision in psychology significantly enables the practitioner to have the required skills to assess and comprehensively treat psychological disorders. This training also enables the practitioner to have the critical research knowledge and skills to manage new evidence based therapies that become developed in the field. Therefore the ACSP would prefer that patients have access to only the

most qualified people to manage and treat their mental health care needs and hopes that over time this will be an outcome.

However, given that there are workforce shortages and the Government currently funds "focused psychological therapies" it may be helpful in the short term, to move the responsibility of the decision about service level from GPs to specialist psychologists. Specialist psychologists are in a better position to firstly, understand the different services provided in the two tiers and secondly, can guide and utilise "focused psychological services" as an adjunct to the main psychological therapy being provided.

Having a higher rebate for specialist psychologists at least signals to community members that they are obtaining treatment from professionals with more advanced training. In turn, this financial structure maintains some incentive for people to do post graduate training, promoting the up-skilling of the workforce and a chance for psychology as a profession to meet international training standards over time.

Some submissions the Inquiry will no doubt receive, may claim that the two years of supervision undertaken after the 4 year degree, is comparable or equivalent to the two years of full-time university post graduate training. We would encourage the Committee to consider this argument very carefully because the supervision process cannot be held as equivalent to a post graduate masters (or higher) degree. (See further discussion on this is in section (ii)).

ACSP Recommendations

1. In the short-term, to maintain the two tier Medicare system as it is.
2. Having specialist psychologists managing the referral process to people providing "focused psychological therapies".
3. Provide educational programs to assist GPs and the community to understand the difference between the two psychology service levels.
4. In the longer term, to gradually phase out "focused psychological therapy" services, as more post graduate providers become available.

(ii) Workforce qualifications and training of psychologists

This heading has been separated into two parts as there are different issues involved:

Training of psychologists

It may be helpful for the Senate Committee to be aware of some of the recent history of psychology training and registration, and the significant difference between Western Australia and the other states. This is important as some of the arguments which may be presented to the Inquiry about equivalence of training between masters based pathways to practice Vs undergraduate pathways to practice, are particularly not valid for WA but are also not valid for other states.

Up until 2010 when National Registration for psychology was introduced, WA was the only State which had specialist registration legally regulated under a State Act. WA also had

generalist registration, to be in keeping with what was only available in the other States. In WA, both registration levels required the completion of an undergraduate degree (4 years) in psychology, and two years professional supervision, but the specialist level additionally required two years post graduate training (at least) in one of the specialist areas of psychology (i.e. masters training or higher). Therefore someone in WA obtained specialist registration with a minimum of six years university training and two years supervision, and a person obtained generalist registration with four years of university training and two years of supervision, representing a clear difference in training levels. Very regrettably, WA lost its specialist registration with the introduction of National Registration, something it had had for over 30 years, and WA was flattened out to the lower registration level, to be brought into line with the other states. The WA Health Minister (Kim Hames) is on record as supporting the specialist level of registration for psychology and spoke on behalf of this at a COAG meeting in 2010. It was a major travesty that an opportunity was lost to improve the registration standards for psychology across the country, and for Australia to lose the only registration standard which met international training standards. The decision regarding specialist registration for psychology will be reviewed in 2013 and the ACSP will be arguing for the undergraduate pathway to be gradually phased out and the minimum training level for professional practice in psychology be post graduate training plus supervision, in any of the 9 specialist areas in psychology.

Before national registration, generalist registration in all States except WA, was gained via either the undergraduate pathway (four year degree) plus two years supervision, know as an apprenticeship pathway, or via the postgraduate pathway (six year degree or more) - but without requirements for extra supervision. The undergraduate pathway is known as an apprenticeship model because the practical clinical skills are attempted to be learnt on the job, under a supervision process. The post graduate pathway involves the completion of a two year full time university course where research skills, advanced knowledge and clinical training are taught under the tuition and supervision of university staff. Post graduate students also undertake a range of supervised practical placements in the field, as well as receiving training and supervision in the university therapy clinic. It is difficult to understand how a once a week supervision process is viewed by some, as equivalent to a two year fulltime program which involves via seminars, tutorials, exams and supervised practical training. The role of supervision is to support and develop already learnt therapy skills and knowledge. It cannot replace the more thorough university monitored training, especially in the complex area of mental health.

The understanding of the difference between these two training models and the significant advantage of the postgraduate program has been published in a number of academic papers. For example, Helmes and Pachana (2006) examined and compared the Australian training pathways with those found overseas and explained that the “apprenticeship model” was used in the UK up to the 1970s and in NZ until 2003, after which it was closed as a route to professional practice. This pathway to professional practice was never permitted in the US. Helmes and Pachana state that the apprenticeship model suffers from inadequate training in the empirical bases for assessment and psychological interventions.

"There is no guarantee of a common core of knowledge, a minimal level of skills, exposure to a minimum breath of patients with a range of diagnoses, ages or problem severity, or that the supervision provides training in current evidence-based practice. In addition ethics training for the 4 year trained practitioners is frequently inadequate" (pg 105).

and it was described by another author (Skilbeck, 2004), as "an awful training route" (p.34).

Post graduate training and supervision is now the standard for professional practice in all OECD countries, except Australia. Unfortunately there has been a lack of good leadership in the profession on this issue, resulting in Australia lagging significantly behind international training standards. The primary aim of these international standards is to protect the public, as poorly implemented therapy or inappropriate therapy can be harmful, as it is in any other health care area.

If anything, the situation has gotten worse over time. For example a one year post graduate program plus one year of supervision has recently been created as another pathway to generalist registration, promoted by the APS. This does not meet the standards of our international partners (UK, US, NZ) and will add to the confusion within the profession and for community members. An even more concerning situation, is the announcement in the APS magazine InPsych (April 2100), of a pilot training program at the University of South Australia, consisting of a three year degree in Psychological Science, as an additional pathway to professional practice.

Below is a table summarizing the multiple training pathways to generalist registration which allow a person to professionally practice in psychology:

No. Years at Uni	Supervision required	Australian Registration level	Meeting International standards (US, UK, NZ)
3 years	unknown	none (yet)	No
4 years	yes (2 years)	Generalist	No
5 years	yes (1 year)	Generalist (soon)	No
6 years	no	Generalist	No
6 years	yes (2 years)	Generalist	Yes
6 plus years	yes (one year)	Generalist	Yes

As stated by Helmes and Pachana *"Of greater concern is the continuing state of affairs wherein multiple paths to professional psychological training persist. The historical lack of coordination between APS and State legislatures may have lead to an increase in the number of poorly qualified and poorly trained people legally entitled to call themselves psychologists, who may in fact form an increasing risk to the public"* (pg 110).

Because of the multiple agendas affecting psychology training in Australia, and the tension this brings, legislators may be required to save the profession from itself! This would in

practice not be difficult, it only requires the examination of what is acceptable training internationally, and regulating on this basis. The national Psychology Registration Board would then be required to set a minimum level of training for registration at post graduate masters plus two years supervision, and gradually phase out of any lesser training pathways. It would also remove professional bodies, such as the APS and others, from the role of promoting and advocating training levels which are not in the best interests of the general public.

It should also be noted that one of the difficulties in the training process is that many capable people who would like to continue studies into a post graduate degree cannot get access due to the limited number of places available. For others, the significant university fees act as a barrier to further studies and when there is a cheaper and shorter route to professional practice, the incentive to do further studies is dramatically reduced.

ACSP Recommendations

1. To phase out of the undergraduate degree (apprenticeship model) as a pathway to registration for professional practice.
2. To require a minimum of a masters degree and 2 years supervision in psychology for registration to professionally practice in psychology.
3. To establish specialist registration for the nine speciality areas in psychology in 2013 under the National Registration Scheme.

Workforce qualifications

General mental health workforce qualifications are probably the most confused and complex out of all health areas. Not only is there difficulty in the psychology workforce, but there are other workforce layers which add to the confusion. For example, the use of the titles “counsellor” or “psychotherapist” are not regulated and have training standards which are even more varied than in psychology. Training is often not undertaken at a university and is often based in private training programs with varying lengths, content and scrutiny. This means that community members do not have a regulation Board to complain to if things go wrong and hence have no protection of their rights or health care outcomes . (Please note that the title “counsellor” is very different from the title “Counselling Psychologist” as the later signifies extensive post-graduate training and supervised practice).

Psychological interventions must also be much more clearly delineated from supportive counselling services, that are typically delivered by para-professionals and non-psychologists. The term "counselling" generally refers to supportive interactions (empathic listening) that allow a person to feel emotionally heard and understood in a non-judgemental and caring interaction. Sometimes some basic problem solving may also be a part of this process. These basic skills are part of building a trusting and therapeutic relationship in psychotherapy as well. Psychological interventions on the other hand, generally involve a diagnostic assessment and leads to the establishment of an individually tailored and planned

intervention, using evidence based therapies. This process is worked through with the client and if new or different issues arise during the course of the intervention, the therapist has the skill and knowledge to design interventions to accommodate the individuals' needs. There is also a clear process to ending therapy, which is especially important for children, and to provide skills to prevent relapse.

Unfortunately there appears to be no clear distinction between general supportive counselling and psychological therapy and intervention in the minds of Government, employing agencies or in the minds of the general public. Some workplaces wanting to provide "counselling" with limited budgets, may employ less qualified or inadequately trained practitioners and either directly or indirectly, encourage the employee to work beyond their training base. Sometimes it is also difficult for those providing general supportive counselling to clearly know their training and expertise limits and recognise when it is their duty of care to refer a person to a specialist psychologist for assessment and therapy. A current example of this has been raised in relation to Chaplains in schools who have been found to offer psychological services they are not trained to do. Sometimes this has lead to an exacerbation of the psychological distress of the child and their family and also to the dismissal of the Chaplain.

With the Federal Government funding NGOs and Medicare Locals to possibly provide psychological services, these settings will need considerable guidance as to who they should employ to do what work, and how training and skills need to be recognised to make sure that community members using these services are obtaining proper treatment and are not placed at risk. Any person with one of the diagnoses listed under Medicare for psychological therapy should only be referred to people with post graduate training and supervision in Psychology.

While the comments above relate to low training levels being used beyond knowledge and skill bases, another equally concerning workforce matter is providing other professional groups with short courses in psychological assessment and therapy and supporting them to do the work of specialist psychologists. For example, the ongoing push by the AMA, APS and the Federal Government to encourage GPs to do short courses in psychological therapy (often for only 6-8 hours) and then have Medicare items to allow them to undertake psychological therapy with their patients. This is also seen in the development of similar short courses for social workers and occupational therapists recently announced by the APS. Specialist psychologists are greatly concerned about this form of professional short cutting and how this could impact the services provided to the general public. If a person attends a practitioner in good faith and finds that their psychological problems are not assisted by the therapist, they may then believe psychological therapies don't help, or that they have failed somehow. Both scenarios can be minimised if patients have access to properly trained people.

It is also difficult to understand why the Federal Government and other decision-makers are choosing to additionally load GPs with these extra areas of practice, when they are already overwhelmed by their medical duties in treating chronic diseases and dealing with an aging population. GPs, whilst highly trained in general medicine, do not have the clinical time (or sufficient training) to undertake psychological therapy. There are already well trained and established professions to do these tasks, (psychiatrists and specialist psychologists) and a

more helpful focus should be on building the workforce of these professions to do the work they are trained to do.

ACSP Recommendations

1. Supporting an educational campaign for workplaces and the public about what the difference between general supportive counselling and psychological therapy is.
2. Educate workplaces and the general public about the level of training and skill needed to undertake these two different forms of work.
3. Monitor the training and skills level of people employed in state government departments and other government funded bodies, to ensure the maximum protection of the public.
4. Creating a climate of that mental health problems are complex and require proper care and treatment, by facilitating training programs which specifically teach people to do this work.

(iii) Workforce shortages

The ACSP understands that a major driver to get people with varied skills into the mental health care is due to workforce shortages. However, any attempt to try to resolve the issue of workforce shortages by this approach is very problematic and short sighted. More helpful ways need to be considered by the Federal Government. There are several ways which have been used to increase workforce numbers in other highly sought after professions, such as medicine, nursing and teaching, which could also be used for psychology. These include, promoting and supporting more post-graduate university training places for Australian students, wavering/subsidising psychology post-graduate fees, providing more funding to psychology university department to employ more people to train post graduate students and increasing the number of positions for specialist psychologists in public mental health care workplaces so they can provide the professional supervision to psychology post graduate registrars.

In addition, there are a number of speciality areas in psychology which provide treatment for a very extensive range of psychological problems and disorders and these specialist need to be more fully utilised. Of the nine speciality areas in psychology, six work more specifically in different but overlapping aspects of mental health and include: clinical psychologists, counselling psychologists, health psychologists, clinical neuropsychologists, forensic psychologists and child and developmental psychologists. To limit in access via Medicare to only clinical psychology services reduces the mental health workforce and the range of services available. All of these specialists need to be more fully utilised in the public and private settings.

ACSP Recommendations

1. Promoting and supporting more post-graduate university training places in psychology for Australian students.
2. Wavering/subsidising psychology post-graduate fees.

3. Providing more funding to psychology university department to employ more people to train more post graduate students.
4. Increasing the number of positions for specialist psychologists in public mental health care workplaces so they can provide the professional supervision to psychology post graduate registrars.
5. Providing financial incentives and career structures in public workplaces to encourage more specialists to work in community based services and to undertake post-graduate training.
6. Increasing the mental health workforce in the private sector by expanding Medicare to include not only clinical psychology services but also other post graduate trained mental health specialists (child and developmental psychologists clinical neuropsychologists, counselling psychologists, forensic psychologists and health psychologists,).
7. Establishing specialist registration for the profession of psychology in 2013.

(g) The delivery of a national mental health commission

The ACSP fully supports the establishment of a National Mental Health Commission. The establishment of State Mental Health Commissions is also fully supported, like currently existing in WA and NSW. We encourage that these Commissions be responsible for researching the mental health needs of their State, what funding levels are required for mental health and to support and promote the proper work conditions and ratios of professionals being employed in sectors receiving state and federal funding. We would also encourage the Commissions to have a good mix of mental health service providers on boards and advisory panels, and people from both academic and clinical positions. This would include having a variety of specialists being able to head such Commissions, rather than just having a medical specialist in the lead, as it would promote a more dynamic and creative process in decision making.

ACSP Recommendations

1. Every State in Australia to establish a Mental Health Commission (MHC).
2. MHCs be responsible for researching the mental health needs of their State.
3. MHCs establish what funding levels are required for mental health care in different sections of their State.
4. MHCs support and promote the proper work conditions and ratios of professionals being employed in sectors receiving state and federal funding.
5. MHCs have a good mix of professionals, who provide a range of mental health care services, on boards and advisory panels, including people from both academic and clinical positions.
6. MHCs having a range of specialists as Chairs of advisory boards and panels, rather than typically having a medical specialist heading the Commission or advisory group.

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(h) The impact of online services for people with a mental illness, with particular regard to those living in rural and remote locations and other hard to reach groups

The barrier of distance to medical and psychological services for people in rural and remote areas is very real and difficult to resolve. The choice is either to bring the services into these areas, or to facilitate people from these areas to come to the services. For the former option, the ACSP supports online face to face psychotherapy services as a possibility for reducing the distance barrier. Online diagnosis and therapy packages which do not involve an actual therapist however are less ideal, as they do not allow the flexibility and individualised care that is very often needed. It also does not recognise the significant role the therapeutic relationship adds to positive therapy outcomes. It will be interesting to see how Telehealth services progress, which have been recently supported by Medicare for medical health, and perhaps mental health can learn from the pros and cons from this program. A difficulty with this option however is the current lack of infrastructure to allow reliable internet access and usage. It is not uncommon, even for large regional towns, to have poor and unreliable internet services, so this pathway to care may take some time to become established and fully functional. It would also be important that issues around patient confidentiality are closely monitored.

Another option in the short to medium term could be for the Government to support fly-in, fly-out specialist psychology services, perhaps linked through the flying Doctor services. The Federal Government could consider going into partnership with large industries in rural and remote areas to develop more opportunities with this form of service delivery. There are already some options like this for psychiatry services.

To facilitate the movement of people to specialist psychology services, an option may be for the Government to provide additional support via Medicare in the form of rebates for double or extended sessions and travel allowances, as is currently available for medical appointments.

ACSP Recommendations

1. In the short to medium term, Government funding for fly-in fly-out psychological services.
2. Online face to face therapy services, with additional telephone link ups, being the minimum requirement for government funded online psychological therapy services.
3. Providing Medicare funded extended therapy services (double sessions) and travel allowances, for people who choose to travel long distances to see specialist psychologists.

(j) Any other related matter.

The current Medicare administrative requirement necessitating a GP review before psychological therapy can be continued is causing significant auditing problems for specialist psychologists. When a GP review cannot be obtained in a timely manner many specialists decide to continue therapy due to their duty of care to their patients. Some specialists have then been audited by Medicare and have been penalised for this decision by being requested to repay money to Medicare. This is in a situation where there is no fraud or over servicing occurring. The conflict arising between the duty of care to the patient and the administrative needs of Medicare, further highlights the need to remove the GP review process. It also seems very unreasonable for the full responsibility for this situation to fall on the specialist when Medicare continues to pay the rebates to the patient when a review has not been recorded.

In conclusion, the Australian College of Specialist Psychologists would like to thank the Senate Committee for developing such excellent Terms of Reference and for reading our submission. We will look forward to hearing the outcomes of the Inquiry and would also welcome an opportunity to present evidence directly before the committee if this is possible.

Yours sincerely

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On behalf of the Australian College of Specialist Psychologists

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