

Executive Summary

Points from the terms of reference addressed in this submission:

- (b) changes to the Better Access Initiative, including:
 - (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;
- e) mental health workforce issues, including:
 - (i) the two-tiered Medicare rebate system for psychologists,
 - (ii) workforce qualifications and training of psychologists, and

Suggested criteria for evaluating submissions

It is my hope that the submissions accepted will be evaluated according to rational scientific and economic principles. I aim in this submission to provide criticisms and suggestions that adhere to these principles except where I venture a clearly indicated opinion:

- Disregard claims unsupported by facts or research, especially when made by people who assert their scientific credentials as a claim to authority
- Value statistical facts ahead of anecdotes
- Value efficient and flexible solutions ahead of costly, selective or inflexible solutions
- Privilege the opinion of clients and carers and their reports of what works for them, ahead of the opinions of practitioners with a financial interest in particular solutions (this includes my opinion, but my financial interest will be clarified later)

Argument summaries for points addressed

- The proposed changes to the number of rebated sessions by allied health practitioners will be detrimental to the outcomes of individual patients, to the flexibility and responsiveness of the mental health workforce and will reduce access to services by patients across the severity spectrum.
- These changes are also contrary to sound medical and economic principles that underpin the funding strategies for other health services.
- The mental health workforce needs to be greatly increased in both number and quality.
- This increase would put mental and physical health on the same footing in terms of equity of access.
- A strategy that rewards practitioners for outcomes rather than methods could provide a natural brake on excessive expenditure while allowing patients to actively participate in choosing the optimal treatment and practitioner.
- This strategy may be challenging to implement, so a simpler and quicker alternative is to slightly increase the number of psychologists attracting a higher level of rebate.

Impact of Reduced Better Access Sessions

The Government's proposed changes will reduce the maximum number of psychology service sessions from 18 to ten. The cost savings proposed by this

measure will be minor relative to the overall cost of the Better Access scheme. When the additional burdens placed on the health system are taken into account though, the savings will be negligible to negative.

The purpose of the Better Access Scheme is to make evidence based treatments available to those suffering high prevalence disorders - generally speaking that is anxiety and mood disorders. In the research that provides the evidence base for treatments for these conditions, the optimal treatment length is between 12 and 20 sessions.¹

An assumption underlying the provision of psychological services through a medical insurance system such as Medicare is that the treatment delivered is the most important factor in the patient's progress. This same assumption is made in medicine. It is wrong in both cases, but especially so in psychological treatment. Researchers in this field have repeatedly found that the alliance between the counsellor and the patient is far more important than the treatment the counsellor applies.²

These alliances take time to develop and clients show clear preferences when given a choice of counsellor. Repeatedly clients have said to me that they would rather stop therapy altogether than to try to re-tell their story to another counsellor. The assumption that effective psychological treatment is just a medical procedure that when carried out by a technically competent practitioner, will produce the desired outcome is not supported by research or patient preferences.

A further problem for many practitioners with the reduction to ten sessions is that for some disorders or some presentations it is simply not possible to carry out an effective treatment program within that limit. I know of several highly effective practitioners working with low-prevalence disorders such as PTSD and eating disorders who know that they cannot successfully engage the client, support the development of the motivation and courage to start facing and working on their problems and then complete the actual therapy in such a brief time. Because of the specialised nature of this work, there are very few such practitioners, but Better Access has given such patients the opportunity to use their services and start to address often lifelong problems. I am concerned that the reduction to a maximum ten sessions will close this treatment pathway for these severely distressed (though sometimes not severely 'disordered') individuals.

This last point brings me to one of the most important considerations in the cuts to the Better Access treatment sessions. I understand that in the first three years of the Scheme the costs far exceeded the budget for the program. To a large extent this is because for years there has been an unmet need for these services.

¹ Harnett, P., O'Donovan, A. & Lambert, M. (2010). The dose response relationship in psychotherapy: Implications for social policy, *Clinical Psychologist*, 14(2), 39-44 and Cognitive behavioral therapy for the management of common mental health problems: Commissioning Guide. National Institute for Clinical Excellence, Retrieved on August 5 2011, from <http://www.nice.org.uk/media/878/F7/CBTCommissioningGuide.pdf>

² See Richard F. Summers and Jacques P. Barber, Therapeutic Alliance as a Measurable Psychotherapy Skill. *Academic Psychiatry*, Sep 2003; 27: 160 – 165 for an example review

We have known that the proportion of mental health spending in the health budget did not reflect the prevalence of these disorders nor their proportion of the total disease burden to the economy or to the individual patients.

It was assumed at the outset that the people utilising these services would be those suffering at the mild to moderate end of the spectrum – sometimes referred sneeringly by those who should know better as ‘the worried well’ or when their postcode indicates a higher socioeconomic status, ‘the worried wealthy’. In fact, many of the people accessing mental health treatment through the Better Access scheme experience severe levels of symptomatology and have been able to achieve some degree of health and functional living because they now have access to non-pharmaceutical treatment. Both the independent Better Access Review and submissions to the Committee by the Australian Psychological Society and other parties have confirmed this.

I hope that the Committee can prevail upon the Senate and the Government to reconsider the reduction in rebated sessions.

Mental health workforce issues including (i) the two-tiered Medicare rebate system for psychologists, and workforce qualifications and training of psychologists.

The two-tier separation is arbitrary

When the Better Access Scheme was introduced in 2006, the Government had been advised, and continues to be advised in some quarters, that only clinical psychologists have the expertise to diagnose and treat mental health disorders. Consequently, for the purposes of the Medicare rebates, and notably, only for that purpose, an artificial division of psychologists into ‘clinical’ and ‘generalists’ was instituted. This division has never before existed in the training or practice of psychology. It does not exist in any other jurisdiction that I am aware of. The Psychology Board of Australia, and psychologist licensing authorities and registration boards in other jurisdictions distinguish between a registered psychologist and one who has completed further specialised study and supervised practice experience.

For example in the United Kingdom, members of the British Psychological Society can either practise as Graduate Member psychologists, or with sufficient training, study and supervised experience qualify as a Chartered Psychologist. This higher level of practice is not limited to those within the clinical psychology area of specialisation. So there are Chartered Counselling Psychologists and Chartered Health Psychologists for example. Their higher standards of knowledge and expertise are reflected by higher salaries paid through bodies such as the National Health Service.

By dividing the profession along the arbitrary lines of ‘clinical’ and ‘generalist’, the two-tier rebate system has effectively penalised those patients whose preference is for a psychologist or other mental health practitioner with a different specialisation or treatment orientation. Remember that as indicated in the previous section, patient alliance with the therapist is more predictive of successful outcome than the training level or speciality of the practitioner.

Along with this artificial division of grades of psychologists, an artificial division of competencies was instituted. According to this division which is the basis for the rebate differential, only clinical psychologists are deemed competent to practise psychological therapies, while generalists were relegated to the much simpler tasks of carrying out Focused Psychological Strategies (FPS). FPS is another fabricated construct. It exists nowhere in the mental health literature and was created originally to distinguish very simple low-intensity psychological interventions such as relaxation training that could be carried out by practitioners such as GPs or community health nurses with limited mental health training.

Therefore the advice the Department of Health and Ageing was given in 2006 was misleading and ignores the specialised skills of other psychological specialists such as counselling, health or developmental psychologists. These specialists are also trained in diagnosis and treatment of the full spectrum of mental disorders.

Current safeguards are sufficient

It must be understood that no postgraduate program can prepare a psychologist for the full range of disorders, presentations and treatment contexts they will face in their working career. For that reason there are two very important safeguards built into ethical psychological practice that ensure that the public can have trust and confidence in our abilities.

Firstly, we are ethically required to not practise outside our area of competence. As the committee will no doubt be aware by now, the two-tiered rebate system has been a source of intense debate and division within and beyond the psychology profession. This ethical requirement I think has been grievously overlooked in these arguments. Supporters of the two-tiered system have, I believe, tried to 'put the frighteners on' with claims that unskilled psychologists will harm individuals whom they are not competent to diagnose and treat. No psychologist should undertake such treatment though. The Psychology Board has measures in place to deter and counteract such unprofessional practice. Protecting patients from such harm should surely come from ensuring that all practitioners practise ethically according to their skill and training, rather than needlessly limiting the practice of all specialist psychologists who are not clinical psychologists.

Secondly, to retain specialist designations (e.g. Psychology Board of Australia 'endorsed status' or Australian Psychological Society specialist College membership) psychologists must undertake continuing professional development. This additional training is undertaken to ensure that the practitioner can maintain and extend their skills in diagnosis and treatment. Any practitioner who achieves competency this way should be able to deliver those treatments once they have completed the necessary training.

A Personal Example

As an example of how absurd these artificial divisions are I would like to report a little of my experience. I am a Counselling Psychologist and therefore, according to the Medicare classification of my profession, unable to deliver 'psychological therapies'. This also means because of the rebate differential, my clients pay a higher 'gap' fee for my service than if they were consulting a clinical psychologist. Many of them report to me that they consequently need to take sessions fortnightly even though I know that sound practice may require weekly sessions. In some cases I assist by taking a reduced fee. I would prefer though that Medicare rebated my clients at a level that did not add to the stress they already experience.

In 2003 I started undertaking individual training in Acceptance and Commitment Therapy (ACT), a new and promising behavioral therapy. As my skills in this approach increased so the outcomes of my clients improved (statistics on this will be provided below). Consequently I received some recognition as a clinical supervisor of other practitioners wishing to develop their ACT skills. Currently among the twelve or so counsellors and psychologists I supervise are two clinical psychologists. Ironically, I am mentoring them in the delivery of treatment that I am not allowed to provide to my Medicare clients. This, notwithstanding that the Royal Australia and New Zealand College of Psychiatrists accepted me as a supervisor of two psychiatric registrars for this treatment model.

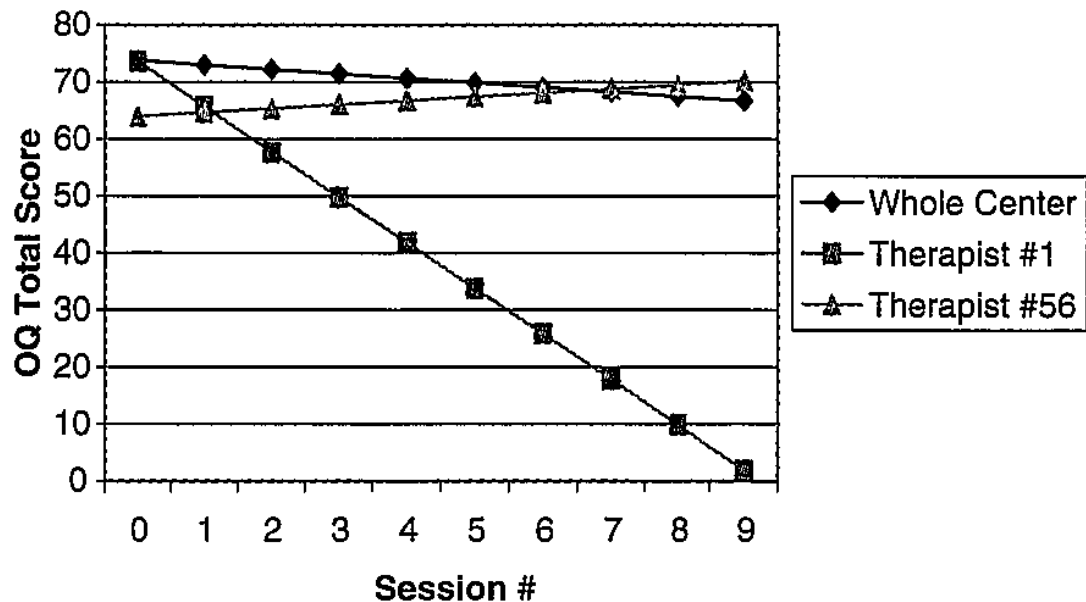
Since 2001 I have recorded simple outcome data for almost all my private practice clients. I use this data in the practice to ensure that when therapy is not progressing well, this failure to improve can be addressed quickly. It is common for therapists to be poor judges of when their clients are deteriorating.³ Having researched this I am aware that my 'clinical judgement' and 'extensive experience' are not reliable guides. So I rely on the data my clients provide. This is the kind of practice academic clinical psychologists are endorsing when they speak of training 'scientist-practitioners'. However it is not the exclusive domain of clinical psychologists. All psychologists and mental health practitioners are capable of gathering and analysing this kind of data. If they did the standards of practice and client outcomes might improve dramatically. In my case for example, 69% of clients seen between late 2004 and mid-2009 achieved as good or better an outcome as could be expected from treatment by the average counsellor. The average number of sessions for a successful treatment was nine.

Unfortunately most practitioners do not collect this data, but I believe that were they to do so, and were Medicare to provide rebates based on improved outcomes, market forces (i.e. patient choice) would very quickly ensure that Better Access funds went to the most effective practitioners regardless of their training background.

No class of therapist is better than another, BUT some therapists are effective, while some are not

³ Hatfield, D., McCullough, L., Frantz, S., & Krieger, K. (2009). Do we know when our clients get worse? An investigation of therapists' ability to detect negative client change. *Clinical Psychology & Psychotherapy*, 17, 25-32.

Figure 1 shows a graphic example of how good and bad individual counsellors can be. In this chart, the “OQ Total Score” shows severity of symptoms and distress. A level of 65 is the typical cut-off on this scale for a clinically affected individual i.e. someone scoring this level or higher would be typical of the patients seeking treatment through the Better Access scheme. In the study from which this graph is taken⁴ no differences in client outcomes were found on the basis of therapist level of training, type of training (clinical psychology vs. counselling psychology vs. social work) or theoretical orientation (i.e. techniques used).



In essence this study shows that while some therapists are excellent (Therapist #1) some are actually worse than useless (Therapist #56). No doubt the Australian mental health workforce contains examples of both kinds. But they cannot be determined by the training background of the individual practitioner. Therefore that should not be the basis for the level of rebates patients receive.

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⁴ Okiishi J, Lambert MJ, Nielsen SL, Ogles BM. (2003) Waiting for supershrink: an empirical analysis of therapist effects. *Clinical Psychology & Psychotherapy*. 10, 361-373.