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Re: Commonwealth Funding and Administration of Mental Health Services

I wish to make a submission regarding Terms of Reference point *(b) (iv):*

The impact of changes to the number of allied mental health treatment sessions for patients with mild and moderate mental illness and the Medicare Benefits Schedule.

Submission Summary

> Reducing the number of, and Medicare Benefit Schedule (MBS) rebate amount for, Clinical Psychology MBS sessions available to patients with mild, moderate (and more severe) mental illness will inevitably undermine the accessibility, effectiveness and economic and social benefits of this program. Reductions will cause harm to mentally ill patients, particularly to patients with conditions currently fitting the MBS criteria of “exceptional circumstances”. Such patients are more likely to avail themselves of a clinical psychologist since a clinical psychologist’s training and professional network is uniquely focused on assessment, diagnosis and treatment of psychopathology. Consideration should be given to providing improved clinical psychology MBS access to such patients in terms of increasing the maximum number of sessions and ensuring the ongoing value of the clinical psychology MBS rebate.

I have practised as a clinical psychologist for thirty years. My letterhead credentials indicate my formal education, my longevity indicates my experience, and my registration and APS membership indicate my ongoing fulfilment of rigorous mandatory professional development. I have publications in peer reviewed journals and have worked in various public and private sector settings. I currently work in a private women’s reproductive health service, occasionally teach graduate students, and have a small private practice where I supervise psychologists and treat GP- or psychiatrist-referred patients (adults and children) via the (MBS) item number 80010. I am committed to enacting my ethical, professional and legal responsibilities to provide the best care I can to my patients.

The MBS inclusion of clinical psychologist services ensures that expert, timely and cost efficient psychological treatment can be accessed by mentally ill patients who otherwise may face a confusing and lengthy path to access public sector mental health treatment, if they are able to access it at all.

Initiatives to bolster public sector services are to be commended. However, patient’s access is often thwarted by strict exclusion criteria, waiting lists, staff

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turnover, relatively small number of designated treatment sessions, limited choice of practitioner, and system inflexibility.

The inclusion of clinical psychology in the Medicare Benefits Schedule provides a ready pathway to psychological care bypassing such public sector obstacles via a direct link between general practitioner, psychiatrist (and ultimately other specialists such as paediatrician, obstetrician & gynaecologist, neurologist and so on), to the clinical psychologist. The clinical psychologist: becomes a key member of a multidisciplinary team of health professionals required for patients with more serious conditions; brings into play effective, evidence based psychological assessments, interventions and therapies not provided by other health professionals; and provides a unique framework clarifying and articulating the problem(s) and indicating necessary referrals and focus of treatment.

While there is some evidence suggesting that ten sessions is the average number of sessions patients access with psychologists in general to effectively address patients' mental ill health, this "average" figure masks the range of patients consulting clinical psychologists in terms of severity of mental ill health and treatment needs. In particular, relying on an "average" figure to set the maximum number of clinical psychology MBS sessions does a disservice to the patients suffering with more serious mental ill health and requiring a higher number of sessions. Given the unique and rigorous training of clinical psychologists in psychopathology, clinical psychologists may be more likely to treat these patients whose mental health conditions are not mild, but who sit in the higher ranges of severity.

In my own practice, a patient suffering an Adjustment Disorder may find considerable relief from one or two sessions involving basic psycho-education, stress management interventions and other evidence based psychological treatment. Or, one session assessing an adult or a child may quickly indicate to me: problems which have been overlooked; suggest that my involvement is not the most appropriate or effective intervention at that time; or that my primary role in caring for that patient at that time is to facilitate the appropriate referral to other medical, psychiatric, paediatric, neurological, educational specialists or organisations, and communicate my opinion. These are sessions well spent in ensuring appropriate diagnosis and treatment.

More typically however, I am consulted by patients meeting criteria for Major Depression, Post Traumatic Stress Disorder, varieties of addiction and occasionally psychosis. These are life threatening conditions. Such patients usually have complex histories of childhood abuse and trauma, are engaged in distressing and harmful relationships and practices (abusive relationships, sexual risk taking, addictions, other self-harming behaviour, financial

problems, parenting problems, isolation), may suffer from other health complications associated with their mental ill health (reproductive health problems such as unplanned pregnancy and sexually transmitted infections, eating disorders, migraines, chronic health problems and so on), and are at serious risk.

These patients meet the current criteria for “exceptional circumstances” and require at least the current maximum of eighteen MBS clinical psychology sessions in the one year. Without effective treatment, there will inevitably be a devastating and expensive domino effect of adverse consequences for the patients, others in their lives (e.g. parents, children, partners, friends) and the community. The costs to individuals, families and the community of suicide, gambling, drug and alcohol abuse, dropping out of education or the work force, family break up, child neglect, poorer physical health and medical treatments, and so on are well known.

The majority of my patients are women. Some are facing mental ill health associated with being currently, or in the past (or both), victims of violence and abuse. Intimate partner violence is “the leading contributor to death, disability and physical illness in Victorian women age 15-44, being responsible for more of the disease burden than many well-known risk factors such as high blood pressure, smoking and obesity”, (VicHealth & Department of Human Services, 2004, p. 10), and is linked to women’s poorer reproductive health (Taft, Watson & Lee, 2004). For example, a woman may be referred by her GP because of depression. Clinical psychology assessment indicates that her depression is linked to her poor reproductive health and a repetitive pattern of dysfunctional and harmful relationships with men which can be traced back to a childhood marred by chronic sexual abuse. My skills as a clinical psychologist have generally allowed me to intervene effectively to break this dysfunctional and distressing cycle. My patients eventually reach the point of no longer meeting criteria for a mental disorder, and are productively engaged in work, relationships and other pursuits.

Some patients are (also) facing mental health issues associated with pregnancy. Research has documented increased mental and physical health vulnerabilities of pregnant women (World Health Organization & United Nations Population Fund, 2009). Some pregnant patients have a prior hospitalisation for psychosis, or past or current Major Depression. This type of patient is at grave risk during her pregnancy and/or post-natally. While the obstetrician focuses on her general physical health needs, and her psychiatrist focuses on her psychopharmacological treatment, she also accesses me to provide her with psychotherapy and psychological strategies and perspective. The potential distress and costs of a(nother) mental health

hospitalisation are minimised and often averted. The patient ultimately embarks on motherhood better equipped for its challenges and with a support network readily accessible if required.

Given that my submission is a public document, I am wary of providing specific case examples where confidentiality and privacy may potentially be breached. But the broad outline above highlights patients who fit the current Medicare criteria of “exceptional circumstances” and who require, and benefit from, a greater number of clinical psychology sessions than “the average”.

Clinical Psychologists try to organize psychotherapy sessions in a way mindful of patient’s financial dependence on Medicare and its inbuilt limits. But any reduction in clinical psychology MBS sessions, especially for patients currently fulfilling the criteria of “exceptional circumstances” and currently eligible for eighteen sessions per year, will sorely undermine patients’ treatment and outcomes via the clinical psychology MBS program.

References

Taft, A., Watson, L., & Lee, C. (2004). Violence against young women and association with reproductive events: A cross-sectional analysis of a national population sample. *Australian & New Zealand Journal of Public Health,28(4), 324-329 .*

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World Health Organization & United Nations Population Fund (Eds, 2009) *Mental Health Aspects of Women’s Reproductive Health: A Global Review of the Literature*. Geneva: WHO