26th July, 2011

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

Dear Senator,

I would like to make the following submission to the Senate Community Affairs Committee Inquiry into Mental Health Services, particularly in relation to the *Better Access to Mental Health Care Initiative* (*'Better Access Initiative'*) and Medicare rebate system for psychologists. I have been a Clinical Psychologist in private practice for approximately four years and have worked within private and public psychiatric/Mental Health services/hospitals for approximately six years. As an Australian citizen, I am writing to express my objection about the Government's proposed changes to the *'Better Access Initiative*' as announced in the 2011 Federal Budget. Specifically, I am disappointed by the proposal that from 1 November, 2011, the yearly maximum allowance of sessions of psychological treatment available to people with a recognised mental health disorder will be reduced from 18 to 10 sessions.

Whilst new investments in mental health care are important and are to be applauded, they should not be at the detriment of existing mental health programs. For example, I understand that the Government has proposed to redirect funding from the *'Better Access Initiative'* to team-based community care (ATAPS). The ATAPS system is more limited, has higher costs of administration and is more difficult for psychologists to access through the GP divisions. Personally, I do not understand this stance and under the existing *'Better Access Initiative'* I have already been able to access and achieve effective gains from psychological treatment. Therefore, I am deeply concerned as to how much those treatment gains will be adversely impacted if the funding for the *'Better Access Initiative'* is effectively halved (18 sessions to 10 sessions per annum) as it implies that the same treatment outcomes can be achieved with half the amount of sessions. The proposed cuts to the *'Better Access Initiative'* reflects the Federal Government's lack of understanding of the specific and varied needs of Australians with mental health disorders.

These proposed changes to the number of sessions eligible for a Medicare rebate to a maximum of 10 per year will have most impact upon those with chronic and complicated mental health issues who require ongoing treatment and psychological intervention, however are not readily able to access this through public Mental Health Services who have a high threshold and multiple step system for entry. The reduction in sessions will place further strain on our under resourced Mental Health Services. Taking a hard line on mental health consumers is not the answer. It is unrealistic to expect individuals in a vulnerable psychological state to immediately establish a rapport with a mental health professional even within the current 12-18 sessions – let alone achieve treatment gains within 10 sessions. I do not need the added pressure or stigma of needing to recover quickly with the threat of being referred to a community team or psychiatrist and therefore having to start again with new practitioners. This approach does not take on a recovery orientated approach and does not empower disadvantaged Australians. Recent statistics support the need for the current 12-18 sessions due to chronic populations accessing services; from

October 2009 to October 2010, 82 per cent of patients referred to Clinical Psychologists were suffering high or very high levels of psychological distress. The proportion who had low levels of distress was only 4 per cent.

In relation to a proposed changing of the rebate for Clinical Psychologists, possibly to the same level as general psychologists, the Medicare initiative from the outset recognised clinical psychologists as a speciality area of psychology in terms of mental health or psychiatric disorders. The APS established a process for any psychologist with experience in the area of mental health issues to apply and undertake some form of bridging plan depending on individual background to ensure equivalence to the requirements for membership of the APS College of Clinical Psychologists. Thus a differentiation has been well established and many psychologists have undertaken various pathways, often at significant personal cost to gain endorsement as a Clinical Psychologist. Currently registration as a psychologist is a six year process, whereas to become a Clinical Psychologist requires a minimum of eight years. Clinical Psychologists by definition deal primarily with a psychiatric population and are more closely aligned with psychiatrists than any other profession. Therefore rather than considering decreasing the status of Clinical Psychologists in terms of decreasing the Medicare rebate to the level of other psychologists generally, consideration should be given to further enabling Clinical Psychologists to specialise in the area of medical psychology as is the case in other countries such as the USA. There is a general workforce shortage of psychiatrists with many patients needing to wait months to access a psychiatrist. In terms of considering a change to the Medicare rebate it should be considered that Clinical Psychologists are already dealing with the same complex clients as psychiatrists and in many cases providing similar assessments and interventions, although the Medicare rebates for psychiatrists may be 2-4 times that of Clinical Psychologists. Therefore rather than any consideration of reducing this rebate it should be increased and further specialisation of Clinical Psychologists should be made possible for Clinical Psychologists to be able to access the same Medicare rebates as psychiatrists. This would be an effective way of addressing the shortage of psychiatrists from a patient perspective, as Clinical Psychologists and psychiatrists already work closely together and almost interchangeably in many settings, apart from the ability to prescribe medication and order medical investigations.

I would like to remind the Senate Community Affairs Committee Inquiry into Mental Health Services that we should be client focused in the decision making process. In addition, the *'Better Access Initiative'* was introduced to address mental health disorders. By definition Clinical Psychology is the only mental health profession (besides Psychiatry) whose complete post-graduate training in the area of mental health. Consequently, due to their theoretical, conceptual, empirical and applied competencies, Clinical Psychologists are specialists in the provision of psychological therapies.

The recognition of the need for Clinical Psychology services is seen in the high value attributed to this profession by the mental health system and the community of consumers and their families and carers. The support for this comes from a number of sources including but not limited to (1) the recommendations of the Western Australia Mental Health Plan and the Ministerial Taskforce; (2) the multitude of successful psychological evidence-supported treatments reported in the scientific literature for many severe mental health disorders; (3) the cost effectiveness of psychological treatments; (4) positive consumer evaluations of Clinical Psychology services.

The 1989–1990 National Health Survey demonstrated a high demand for Clinical Psychological services. 43,000 Australians consulted a psychologist over a two week period and required 63,000 consultations (Jorn, 1994). The skills and quality of services provided by Clinical Psychologists have also been recognised by the managers of Mental Health Services in West Australia, General Practitioners and consumers and most recently by the Psychology Board of Australia.

As part of the workforce reform recently undertaken within the Mental Health Division of the Health Department of Western Australia managers and senior Psychiatrists were consulted about their views of expanding the career structure of Clinical Psychologists by creating a number of senior specialist positions (McDonald, 1998). Many of the people surveyed noted that Clinical Psychologists provided a valuable service. General Practitioners are the primary source of referrals under the *'Better Access Initiative'*. In December 1996, the Clinical Psychologist of Osborne Park clinic conducted a survey of the General Practitioners in the North Metropolitan Region. Of the 58 General Practitioners who responded to the survey, 58% indicated a preference for Clinical Psychology services for patients referred to Osborne Clinic, and 87% considered individual therapy to be an appropriate treatment option. Consumer groups were also consulted by McDonald (1998) as part of the workforce reform described above. The feedback from these groups was hugely supportive of the services provided by Clinical Psychologists, finding the work completed with Clinical Psychologists extremely useful. Additional to this West Australian information, a survey of the readership of a leading consumer magazine in America reported that most of the respondents who had received psychotherapy were satisfied with their treatment and thought that it had improved the quality of their lives (Consumer Reports 1995).

As the recent Federal Budget suggests, the current economic and political climate demands increased accountability and cost effectiveness from Mental Health Services. Health Service effectiveness is often seen in terms of savings in bed days per patient and/or DRG, and of a decrease in outpatient activity (increased throughput and decreased recurrence and relapse). Professor Schwartz (1997) has reported the outcome of his studies of the cost effectiveness of psychological therapies. He cogently presented his argument in terms of the expenditure of the health dollar and the benefits measured in dollars. This is difficult to analyse in psychotherapy, therefore he uses the concept of qualified adjusted life years or QALYs to help determine effectiveness. A QALY expresses in a single number a person's individual tradeoff between the length and quality of life. Because a QALY is not tied to a specific condition, health authorities can use it to compare disparate conditions. This analysis has provided some data to show that psychological therapies are effective. Schwartz (1997) has also presented other promising preliminary findings from the industry and health care areas. An Equitable Life Assurance study in America found a $5.52 increase in productivity for every $1 spent on Cognitive Behaviour Therapy for stress-related disorders. Health maintenance organisations in the USA found that including psychological therapy as a benefit reduced monthly medical costs by $9.41 per patient.

Data has been collected within health services that show cost reduction, decreased inpatient bed days and reduced utilisation of costly medical services with the provision of Clinical Psychology services. Data from the Department of Clinical Psychology at the Austin Hospital, Melbourne, discovered savings of between $185.00 to $16,346.00, which

translates to an average saving of $4,161.00 across a sample of ten patients (Milgrom, Walter & Green, 1994). The Department of Health's Manpower Planning Advisory Group of the United Kingdom published its review of Clinical Psychology in June of 1990 after it had commissioned research by the Management Advisory Service to the NHS. The conclusions of this report is published in a briefing paper published by The British Psychological Society. The conclusion of the Management Advisory Service is summarised in the following way; "There is evidence to show that brief psychological interventions can reduce the use of other health services, making savings which are greater than the cost of providing psychological services, the medical off-set phenomenon (The British Psychological Society).

A review of interventions with young children adolescents and their families has substantiated the positive contribution of Clinical Psychology. The Watts (1989) review into the efficacy of clinical applications of psychology discusses the results of a number of research reviews which support the clear conclusion that children and adolescents who receive treatment fare better than those who are not treated or are treated via other means than psychological therapies and that psychological therapies are the treatment of choice for this age group. Jensen, Hoagwood, & Petti (1996) documented positive mental health outcomes for psychological therapies as did The American Psychological Association's Division of Clinical Psychology who constituted a taskforce in 1993 to define empirically validated treatments, review the effectiveness of such treatments and educate the public about effective psychotherapies.

Senator / Minister, I urge you to reject these proposals immediately and instead maintain the current amount of treatment sessions available with a Clinical Psychologist under the *Better Access to Mental Health Care Initiative* to be 12, with an additional 6 sessions for 'exceptional circumstances'. In addition I urge you not to reduce the Medicare rebates for Clinical Psychologists and General Psychosists.

I trust that my feedback will be given due consideration.

Yours sincerely,