

11 September 2011

Mr Ian Holland
Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600



Dear Mr Holland,

Re: Points of clarification put on notice

I have gone over the Hansard from 5 September 2011 to identify areas where clarification was sought and questions were put on notice. This information can be summarised into five main areas: (1) length of treatment; (2) reasons for early termination after 6 sessions; (3) the structure of the Better Access program; (4) psychiatrists as replacements for psychologists; and (5) conflicts of interest. I request that the last section be kept confidential given that clarification was sought whilst 'in camera' at the hearing

Length of Treatment

As stated during the hearing, there is extensive scientific evidence from randomised and controlled trials (RCTs) that demonstrates that at least 15 to 20 sessions of psychological treatment are required for the treatment of the high-prevalence mental health disorders targeted by the Better Access program. This recommended length of psychological treatment is the shared consensus of the *Cochrane Collaboration* (UK), the *National Institute for Health and Clinical Excellence* (UK), the *National Guideline Clearinghouse* (USA), the *US Department of Veterans Affairs*, the *National Health and Medical Research Council* (Australia), and the *Australian Psychological Society*. Each of these groups has independently conducted gold-standard reviews of the research to arrive at this shared conclusion about the length of treatment required for the most widespread mental health disorders such as depression, anxiety and post-traumatic stress disorder. For the sake of being concise, the ACP has summarised and drawn information from these reviews together for your consideration: <http://betteraccess.net/index.php/information/evidence-based-reform>

It bears repeating the point that people with mild to moderate mental health disorders need to be offered a length of treatment that is consistent with the evidence. The majority of data from research applies to mild to moderate cases. Research trials for mild to moderate cases of depression often investigate treatment periods spanning periods of up to 24 sessions; and for more complex and chronic mood disorders, such as dysthymia, an average of 31 sessions has been reported as the requirement to produce lasting remission (Imel et al., 2008). In any case, it is vital for policy-makers to understand that there are high rates of people in Australian society who are severely depressed and struggling with severe levels of anxiety. Whilst it is important to develop programs for psychosis and bipolar disorder, these low-prevalence

conditions are not the only severe disorders. Depression and anxiety are high-prevalence conditions that often reach the point of being severe mental disorders before a person reaches out for help. Left untreated, severe depression and severe anxiety can equally as debilitating and fatal.

During the hearing, Senator Moore questioned the figure provided in the ACP submission that the entire 10 sessions of psychological treatment being offered in the new framework could be used by a person within a two month period. The original statement that Senator Moore refers to is on page 7 of the open letter to the federal Minister for Mental Health, the Hon Mark Butler, which states:

“The position of the Government that the most widespread mental health problems can be fully treated in just over 2 months, is nonsensical.”

Typically speaking, appointments for psychological therapy occur at weekly intervals. Under the new proposal to cap sessions at a maximum of 10 appointments, this means that it is likely that in many instances all 10 appointments will be used within a 10 week period. With there being 4 weeks in a month, this duration of time corresponds to 2 months and 2 weeks. Therefore the ACP stands by our former statement that the plan to limit psychological treatment to 10 sessions carries the expectation that mental health disorders can be fully treated in just over 2 months. We maintain that this policy attempts to rush people through treatment and will therefore set psychologically vulnerable people up to fail.

At the request of Senator Moore, an audit of my current cases has been completed to investigate the period of time over which 10 sessions are used. The audit identified 29 cases where there was a continuous period of treatment spanning 10 sessions or longer. Within that sample, just under half of those people (48.28%) used all 10 sessions in less than 3 months (i.e., just over 2 months). Around one in six people (17.24%) used all 10 sessions in 2 months or less. This figure rose substantially when the most severe and complex cases were examined. Within that smaller sample of 21 cases, 61.9% of people used all 10 sessions in less than 3 months; and nearly a quarter of people (23.8%) used all 10 sessions in 2 months or less.

The implications are straightforward - a large proportion of people receiving psychological treatment do use all 10 sessions over a period of approximately 2 months. This finding aligns with the largest review of treatments for depression, the NICE Guidelines (2010) which made the following recommendations about the length of treatment for all cases of depression (p. 298):

- 8.11.4.2 For all people with depression having individual CBT, the duration of treatment should typically be in the range of 16 to 20 sessions over 3 to 4 months. Also consider providing:
- two sessions per week for the first 2 to 3 weeks of treatment for people with moderate or severe depression
 - follow-up sessions typically consisting of three to four sessions over the following 3 to 6 months for all people with depression.

Reasons for Early Termination After 6 Sessions

Questions were raised during the hearing about the range of reasons why people may pull out of psychological treatment after just 6 sessions. A range of explanations are listed below, to

demonstrate that there are actually a number of factors that may account for this, beyond whether the patient only requires those 6 appointments:

1. **Patient Confusion:** In some instances a client is told by their GP that they can only receive 6 sessions. Consumers may misunderstand this to mean that this is the maximum number of Medicare-funded appointments they can receive, rather than the number of appointments they can have before a review with their GP.
2. **Trouble Booking a GP Review:** Clients sometimes report that they have difficulty getting an appointment with their referring GP to renew the 'Mental Health Care Plan'. In some cases, the client will simply give up because it becomes too hard to get continuity of care from their trusted psychologist within the Medicare system.
3. **Premature Termination After Early Improvement:** When a client makes gains early on in treatment, they may over-estimate their ability to cope independently. This can occur after antidepressant medications begin to take effect for instance. These clients often return for further psychological treatment 6 to 12 months later.
4. **Client Readiness for Therapy:** At the beginning of psychotherapy, it is not uncommon for a client to have upsetting experiences as a result of reflecting on painful or traumatic events for which they are receiving treatment. People sometimes over-estimate their readiness to address psychologically distressing experiences and they may return for proper treatment later.
5. **Judgement:** For an anxious or depressed person, going to a GP to have one's progress with a therapist reviewed can be an intense experience where they may feel judged. In some cases, a client will avoid going back to their GP to have their 'Mental Health Care Plan' renewed out of anticipation for the perception of being negative evaluated or an associated fear of failure.
6. **Practical Issues:** For those who experience complex problems, there can be practical barriers that prevent them from continuing therapy. In complex cases, therapy may be interrupted by the need for the client to resolve other significant problems in their life, reducing the amount of sessions they receive in the program for that calendar year until a later point in time.
7. **Client-Therapist Match:** Locating an appropriate practitioner with the right skill set that is matched to the needs of an individual client is not always straightforward. When a person does not form a solid working alliance with their psychologist, they will often disengage. They will not always resume therapy immediately with a new mental health practitioner.
8. **Stigma:** There are instances where people do not wish for their problems to be reported back to their GP, as required by the current Medicare system. Some clients may opt for private treatment, at a significant personal cost (sometimes to their detriment) simply because they do not wish for their problems to be notated in their medical record.

As can be seen above, there are a range of reasons why a person may disengage from receiving services in the Better Access program (or any other program) that have absolutely nothing to do with their genuine need for treatment. Therefore the arguments that the Senate Committee have heard from some vocal critics claiming that less psychological services should be offered on the basis of a low mean number of sessions being utilised, is a highly questionable conclusion to draw from the limited data we have available. Offering an appropriate number of sessions for treatment is necessary to ensure that people are able to resolve their problems properly when they are willing and able to do so.

Structure of the System

Confusion was noted from the senators about the original basis for the two-tiered structure of the Better Access program. The reason for this confusion appears to be due to the fact that government sources state they structured the system the way they did on the advice of the APS; whereas conversely, the APS points the finger squarely at the government for this decision. During the hearing, I advised the Senate Committee that I have documentation confirming that the APS advised the government to structure the system in the way it is now. For your reference, I have attached the first two submissions lodged by the APS to DoHA that prove conclusively that the APS advised the government to structure the program the way it is presently (Appendix 1 and 2).

From the perspective of the ACP, the major problem is that the two-tiered system discriminates against both clients and practitioners. The system discriminates against consumers by offering a smaller Medicare rebate to people when they seek the services of a mental health specialist from any area other than 'clinical psychology'. Specialised practitioners in other mental health areas face professional discrimination in the system by being forced to undergo a costly and time consuming process that demands association with a private body (the APS) and requires them to meet the requirements for entry to the APS College of Clinical Psychology – a completely separate specialist area to their own. This policy discourages people from accessing the full range of psychological services available from our existing pool of mental health specialists in Australia, which would otherwise allow for a better match of specialist skills to the presenting needs of individual cases. The ACP contends that the problem could be almost entirely resolved by granting automatic eligibility to provide top-tier Medicare rebates in the Better Access program to both clinical and counselling psychologists, due to the fact that both groups are appropriately specialised in providing mental health care services to people in the general community setting.

Psychiatrists as Replacements for Psychologists

As stated in our submission, the ACP does not accept that services from psychiatrists can replace the services provided by psychologists. The major problem here is that increasingly, psychiatrists are no longer being trained in psychological therapies, with many psychiatrists focusing their work on accurate diagnosis, case formulation, and medication management for the presenting condition. The federal Minister for Mental Health, the Hon. Mark Butler, has repeatedly made comments in the media, implying that services from psychologists can be replaced with the services of psychiatrists, for example (see <http://bit.ly/kDIWZ5>):

“People who need over 10 sessions of allied mental health services a year will still receive care through a range of other services including 50 psychiatrist services per annum through Medicare.”

This rationale was later disseminated via an official DoHA fact sheet (see <http://bit.ly/orjsvP>)

The Association of Counselling Psychology thanks you for the opportunity to clarify and we are hopeful that the current Senate Inquiry will make a difference for the people we serve.

Yours Truly,

A handwritten signature in blue ink, appearing to read 'B. Mullings', is positioned below the closing. The signature is fluid and cursive.

Ben Mullings (Chair)
Association of Counselling Psychology