

**4<sup>th</sup> August, 2011**

We are a group of experienced Clinical Psychologists who work in a range of settings including private practice and university research settings. We are very concerned about recent proposed changes to the mental health services discussed in the recent budget announcement. We would like to address several issues in the Senate Inquiry into the Commonwealth Funding and Administration of Mental Health Services.

**Item 1: “the impact to changes to the number of allied mental health treatment services for patients with mild or moderate mental illness under the Medicare Benefits Schedule”**

The advent of the Better Access to Mental Health Scheme allowed people with a mental illness, referred by their GP or Psychiatrist, access to 12 sessions (per calendar year) of treatment by a Psychologist with a substantial rebate for these sessions, and an additional 6 sessions for more chronic cases (a total of 18 sessions).

- According to the Minister for Mental Health (Hon. Mark Butler) the changes are based on the statistics that the majority of patients who used this service had less than 10 sessions of treatment, and therefore only 10 are needed. This very simplistic analysis fails to take into consideration the following:

- That many of the patients may have only accessed 10 sessions in one calendar year, but also used sessions in the subsequent calendar year eg. if a patient presents for treatment in September they might only have 6 sessions in the first year and then another 6 in the second year.
- It also fails to identify that clearly this scheme was not being abused or over-used and that people with mild to moderate conditions only utilised the number of services needed.
- It also fails to take into consideration that an adequate course of cognitive behavioural therapy takes 10-18 sessions of treatment in order to be effective both in the short term and in the long term.

- We are very concerned about the cuts to sessions for the people who need more than 10 sessions. The proposed reduction of treatment sessions could impact detrimentally in a number of ways, including:
  - Insufficient time to provide adequate treatment- resulting in ineffective treatment
  - Greater relapse rates e.g. people suffering from depression are less likely to relapse if they received psychotherapy (Cognitive Therapy) compared with pharmacotherapy
  - Greater reliance on medication as primary form of treatment
  - Decreased productivity at work
  - Decreased functioning e.g. inability to hold down a job; increased demand for part-time work

- Increased sick-leave, and days off work
  - Increased applications for disability pensions
  - Increased time as a psychiatric in-patient
  - Increased duration and severity of the depressive episode
  - Increased presentations to GP clinics, psychiatrists offices and community health (who are already overburdened and have excessive waitlists)
  - Increased presentations to emergency departments
- Research focused on prevention of anxiety and depression clearly indicates that intervening as early as possible (when the symptoms are still mild) results in vast improvements in wellbeing and prevents further anxiety and depression, and this is extremely cost effective. In older adults, mild anxiety and depression symptoms left untreated increase the risk for dementia, morbidity and suicide.
  - It seems unlikely, therefore, that a reduction in number of treatment sessions would result in the desired reduction of cost burden
  - And it seems more likely that patients with a mental illness will receive inadequate treatment
  - Moving those patients with severe mental illness to the ATAPS scheme is completely inappropriate (see below)
  - The benefits of treating mental health in mild and moderate cases are far reaching and go well beyond the welfare of the individual. It seems it has been forgotten that by assisting patients with mild to moderate presentations also reduces absenteeism and medication use, and increases productivity.

**Item 2: “the impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program”**

It is proposed that instead of offering treatment to those with severe mental health disorders under Medicare that the treatment of severe cases will be focused under the ATAPS scheme, and this is also problematic for a number of reasons. The ATAPS scheme is run through the Divisions of General Practice. However, there are enormous differences in the way each Division runs the scheme as this prejudices providers and patients in some areas. For example:

- The schemes are administered by people not trained in mental health and therefore they do not always implement the schemes in ways that are most effective for people with mental illness. The administration of this scheme also

has huge administration costs that reduce the funds available to treat people with mental health problems.

- ATAPS is delivered with “no gap” to patients in some regions, and up to a \$35 gap in other regions. This is extremely unfair to patients who should be entitled to the same service as people in other regions for the same costs.
- The number of sessions that patients can access through this scheme is also different for different regions.
- Once a Division has used up its allocated “pot” of money, no new referrals are allowed. So what happens to those with severe mental illness then? They are left without being able to access a psychologist at all.
- There is no consistency about whether GST should be charged for these services, with GST being charged in some regions and not others. This results in different costs for the administration of the scheme.
- Not all psychologists can register to become providers under the ATAPS scheme. The administrators in each Division are allowed to CHOOSE which providers can get access to the scheme. The administrators who run these schemes do not have the knowledge to make decisions about which providers are better qualified or equipped to treat patients with severe mental health problems. It also means that once enough providers are listed in a Division other psychologists are not allowed to register for the scheme. This is then unfair to patients who are restricted as to which providers they can see under the scheme.
- By moving the treatment of more severe cases to ATAPS, the continuity of care is removed. As not all clinicians are allowed to be on the ATAPS scheme (as described above) then their patients with severe mental health problems will not be able to continue to see the same clinician, and instead will be forced to see a new clinician under the ATAPS scheme.
- The remuneration offered to providers under ATAPS varies enormously from region to region. This is unfair to providers who are often paid very differently from their colleagues in the next region. For example remuneration rates vary from about \$85 - \$135, for exactly the same services.
- The remuneration paid in most regions is also substantially less than what a clinical psychologist might be paid through Medicare for bulk billing (\$119.80), and involves a lot of paperwork, invoicing and delays in payments. As a result few clinical psychologists are registered with ATAPS, and this then means that the most severe mental health patients are being seen by the least trained psychologists and providers, who in fact often get a “good deal” as they are paid more under this scheme than through Medicare. This reduces the effectiveness of the treatment delivered and the outcomes of that treatment. The most complex cases should be seen by the most highly trained.

**Item 3: “the two-tiered Medicare rebate for psychologists”**

- The two-tiered rebate system recognises the additional training and supervision required to become a Clinical Psychologist. Clinical Psychologists have a minimum of six years full time university training with two additional years of mandatory professional supervision in the practice of Clinical Psychology. In total eight years of training are therefore required in order to qualify as a Clinical Psychologist.
- As a result of their training, Clinical Psychologists are equipped to diagnose and treat severe mental health problems
- Four-year trained Psychologists are now being phased out with registration standards being increased to a minimum of six years of full-time university training. This recognises the need for training beyond the initial four-year degree in the practice of psychology. The new registration standards will be consistent with the British and North American requirements.
- The very high level of specialist competence of Clinical Psychologists is recognised by the two-tiered pay scale employed by the Public Health Sector for Clinical Psychologists and Psychologists.

**Item 4: “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”**

- There is scientific evidence of the effectiveness of online psychological treatments of mental illness. The research indicates that evidence-based interventions such as cognitive behaviour therapy that teaches patients skills to manage their emotions and behaviours can be effectively delivered over the internet and through other computer based programs in adults (Cuijpers et al., 2009, Spek et al., 2007). There is also research now being conducted that demonstrates the effectiveness of these formats for children and adolescents as well (Griffiths & Christensen, 2006).
- These programs are even more effective when coupled with some additional support, as in telephone support or email support, from a trained therapist to assist the patient in applying the skills taught to their personal lives (Cuijpers et al., 2009, Spek et al., 2007, Titov, 2011).
- There is also evidence that telephone based interventions are effective, and in fact, as effective as face-to-face treatments.
- The Australian Senate Select Committee on Mental Health report (2006) encouraged the use of this “new way of targeting problems” and stresses the added benefit of anonymity, which would likely lead to reduction of stigma for many users.
- The current ATAPS and Medicare schemes do not cover therapy delivered by telephone or any means other than face-to-face. This excludes many people in

rural and remote areas, who cannot travel to the town where the therapist is based on a regular basis. Also, it means that delivery of effective treatment must be done by the most cost ineffective method, which is face-to-face treatment. Changes should be made to the current systems so that clinicians are allowed to, and encouraged to, offer telephone, email or internet based (chat, Skype) services as a support to clients using computer based programs in regional areas. In order to encourage clinicians in the city to service those in rural and remote communities, these item numbers should be restricted to patients living at least an hour away from a city.

- Psychiatrists are encouraged to utilise non face-to-face methods of treatment delivery to patients living outside their local area. This scheme should be revised and extended to psychologists and other health professionals.

### **Conclusions**

We are concerned that the proposed changes will impact greatly on the welfare of our severely mentally ill patients. We appreciate that costs need to be cut, but these proposed changes are not good cost cutting ideas, instead, they are likely to increase costs through burden to community and economy by delivering to people ineffective doses through Medicare, and then not allowing the most skilled clinicians to offer services to those patients under ATAPS.

One major concern is that the effectiveness and impacts of the Medicare and ATAPS schemes have not been well established. It has not been studied whether the schemes have resulted in the desired reductions in presentations to emergency departments and psychiatric wards, GPs and psychiatrists offices. More research is needed to clearly establish the true effectiveness and consequences of these schemes, including detailed cost analyses. Making drastic changes to this scheme prematurely is a great mistake.

Alternative cost cutting ideas might be:

- 1) Abolishing the ATAPS scheme, and instead encouraging the treatment of severe mental health cases, and patients with low SES or other disadvantages by adding in a specific Medicare Item number that requires these patients to be bulk billed, and allowing individuals referred under this item number to access a higher number of sessions for treatment.
- 2) Increasing the scheduled fees and rebates offered for group psychological programs. This is a cost-effective way of treating a large number of patients with similar problems. There is plenty of evidence to demonstrate the effectiveness of group CBT programs for a range of mental health disorders in children and adults. Unfortunately, the current scheduled fees and rebates offered discourage clinicians from running groups as excessive out-of-pocket fees need to be charged in order to make the running of groups cost effective.
- 3) Encouraging the use of computerized programs for the treatment of mental health issues, as these require less therapist time.
- 4) Teaching GPs more broadly how to apply CBT to milder forms of mental disorders so that mental health providers can be used to treat more serious cases.

We finish with a case-in-point:

*One of our psychologists is currently treating a young mother of two who has recently separated and is involved in a bitter custody dispute. She is experiencing extreme financial hardship and is forced to live in a hostile living environment with her two young children. She suffers from severe anxiety and depression, and prior to getting help from a psychologist was engaging in frequent self-harm and had made a suicide attempt as she could not see how she could ever resolve her situation. She had made several admissions to the emergency department and to psychiatric wards. Since starting psychological intervention (in March 2011), she has made enormous gains, however, her financial difficulties, housing difficulties and custody dispute are still ongoing. In November 2011 when the proposed changes will take effect, she will have accessed all 10 of the sessions that will be available to her through Medicare. In the local Division of General Practice, the treating psychologist has been told twice that there are too many providers in the area and so she is not allowed to become an ATAPS provider, so therefore, her treating psychologist will not be able to continue her care of her. The young mother will be forced to either start over with a new psychologist (which she is unlikely to do as she has difficulties trusting people and forming relationships), or she will have to rely on her GP (who has previously said that she feels that there is nothing she can do to help this patient). It is likely that without the right support, this young mother will revert to presentations to the emergency and psychiatric wards.*

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