Committee Secretary
Senate Standing Committees on Community Affairs
PO BOX 6100
Parliament House
Canberra ACT 2600

4 August 2011

Dear Committee Secretary,

Re: Submission for Senate Community Affairs Committee into Commonwealth Funding and Administration of Mental Health Services.

I wish to address the following terms of reference:

b (ii) the rationalisation of allied health treatment sessions

b (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

c the impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program

e (1) the two-tiered Medicare rebate system for psychologists

b (ii) The rationalisation of allied health treatment sessions

Background
I work in a private psychology practice in the north east of Adelaide. It encompasses a number of low socioeconomic suburbs. At least 25% of my caseload is comprised of clients who have multiple issues in addition to their complex psychological problems. This includes poverty, ill health, gambling, domestic violence and substance abuse. These clients have not been able to access appropriate treatment in the state mental health service, which is significantly under-resourced and has a very small number of psychologists employed in it. Those who did receive a service were not offered access to a psychologist and did not find their experience helpful. Some even found it stigmatising and detrimental to their mental health.

Until a few years ago I worked in the state mental health service and have seen firsthand how inadequate it is. Many clients, particularly those with the more common disorders such as anxiety and depression, simply could not access any services. Even those with quite severe symptoms were often refused services or offered services that were grossly inadequate.

The introduction of the Better Access program enabled thousands of clients, who could not obtain appropriate services in the past, to access psychological treatment in the community. For the first time these clients could access services in a timely manner and without having to go through the bureaucracy of the state-based mental health system, which appeared to be setup to exclude as many client groups as possible. It is my understanding that the reviews of the Better Access program have indicated very positive results and the program was found to be a very cost-effective method of delivering quality mental health services to clients with mild, moderate and severe symptoms.

Reducing the number of allowable sessions from a maximum of 18 to 10

It is of great concern that the Government is intending to cut the number of allowable sessions to clients with complex needs from a maximum of 18 to only 10 sessions. The proposed cuts appear to be based on the assumption that most clients who are referred to psychologists present with mild to moderate symptoms of anxiety and depression. Reviews of the program have shown this is not the case and most clients have moderate to severe symptoms. Hence, if the maximum allowable sessions is cut from 18 sessions to only 10 sessions, those who have more severe mental health issues will not receive adequate treatment. These clients are often also the most socially disadvantaged and have no capacity to pay for services. This means that many clients will only be able to be partially treated, leaving them vulnerable to relapse.

It is not unreasonable to expect that this will result in increased presentations to hospital emergency departments and increased use of the already severely stretched public mental health crisis services, in addition to expensive hospital admissions. All of these scenarios will significantly add to the cost of treatment for individuals. Further, given the inadequately staffed acute services, and the lack of hospital beds for patients with mental health issues, it is possible that there will be a rise in the number of deaths by suicide. Then there are those clients who have had negative experiences with the Assessment and Crisis Intervention Service, many of whom have told me that they would never contact this service again, no matter how unwell they were.

Some of my clients have told me that without the service they have been able to obtain from me under the Better Access to Mental Health program that they would have died (by suicide) or ended up in prison. Instead, their symptoms have reduced and they are able to function better in the community. Some have managed to return to work or study after years of unemployment or being on a disability support pension.

Under the proposed changes, clients with moderate to severe symptoms will be faced with four choices:
1) stop accessing treatment,
2) transfer to ATAPS (see section below for further comments),
3) see their GP frequently, or
4) see a private psychiatrist
None of these options are adequate and all are costly.

A number of my clients have already told me that they will choose to either stop accessing treatment or see their GP more frequently. This will increase the workload of the GP, who

referred the clients to a psychologist in the first place because they didn't have the capacity or the skills to assist the client further. Some of my clients who have severe symptoms were seeing their GP as often as weekly before being referred to me.

GPs will need to consider the alternative options for these clients and could be reluctant to refer to ATAPS if it is seen as a poor substitute where their complex clients are unable to obtain the highly skilled services they need and there is no guarantee that they will even see a psychologist.

Other clients may be referred to a private psychiatrist. As very few of them bulk-bill, and the gaps they charge are prohibitive for most low income earners, this will not be a viable option for many clients. In comparison to seeing a private psychologist through Better Access, this is an enormously expensive alternative and would increase costs to the Government. It is my understanding that private psychiatrists can see clients for up to 50 sessions per year. The majority of clients with anxiety and depressive disorders do not need to see a psychiatrist. If clients require medication most GPs are quite capable of prescribing it at a much reduced cost. Psychiatrists are not normally extensively trained to provide cognitive behavioural therapy, which is generally held to be the treatment of choice for these disorders, and tend to use therapies which are much longer-term and therefore enormously more expensive. Some clients will find being referred to a psychiatrist to be stigmatising.

b (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

It is not uncommon for clients whose symptoms are deemed to be in the mild to moderate range to require more than 10 sessions. Even though a client's overall symptoms may be moderate they often present with more than one diagnosis. In fact it is rare that I see a client who has a single diagnosis. If clients presents with more than one anxiety disorder and a depressive disorder, each of these disorders need to be treated. Whilst there is overlap in the treatment for such disorders, there are aspects of each disorder that need to be specifically targeted. The most common presentation that I treat it is a combination of panic disorder, generalised anxiety disorder and depression. The required number of treatment sessions for adequately treating generalised anxiety disorder alone can be anything up to 14 sessions (as recommended by Dr Adrian Wells, a world-renowned expert in anxiety disorders), and sometimes more with particularly avoidant clients. It is not uncommon for therapy to be interrupted by other life issues affecting the client that cannot be ignored, such as relationship breakdowns, bereavement and so on.

Further, I have had numerous clients referred to me to me who on initial presentation appear to have moderate mental health issues, but during the course of therapy other significant issues come to the fore. Hence the client would then be classed as having severe mental health issues and under the proposed changes they would no longer be eligible for my services. Often in these cases there is a worsening of symptoms before an improvement

occurs. For example, I saw a client who was referred for treatment of panic attacks and moderate anxiety. It took a number of sessions before she was able to divulge sexual abuse by a parent. Her symptoms became quite severe to the point of considering hospitalisation. It took two years of seeing this client to work through the issues resulting from the horrific sexual abuse. As we were approaching the end of therapy she divulged even more horrific sexual abuse by another family member. Simply attempting to treat her panic attacks and anxiety in ten sessions or less would have failed because the underlying cause would not have been uncovered or addressed. Under the proposed changes such clients may even be placed at further risk because after finally disclosing these issues they will then have to be told that there are not enough sessions to assist them and they have to go elsewhere. This places psychologists in a very difficult professional and ethical position. Whilst the example I have used is at the more extreme end, I have seen many clients whose apparently moderate mental illness has masked deeper underlying problems which have sometimes taken a number of sessions for the client to feel comfortable to disclose.

In summary, I believe that the proposal to reduce the number of available services for clients with mild to moderate mental illness makes no allowance for multiple diagnoses, deeper underlying issues, and other life issues that arise during the course of therapy. It is therefore likely that a number of clients who fit into this category will be inadequately treated after completing 10 sessions of therapy, and they will be vulnerable to relapse.

(c) The impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program

There are a number of problems with channeling clients with more severe symptoms into ATAPS.

Firstly, it would be naïve to think that all clients assessed as having complex needs will go directly to ATAPS and not start in the Better Access program first. Many will have already seen a private psychologist through Better Access and will choose to continue with this, even if it means waiting months to be eligible for more appointments after their allocation of ten has been reached. Others will simply drop out of therapy.

If the client agrees to be referred to ATAPS, in addition to having to spend a number of sessions building rapport with a new therapist, there is no guarantee that that therapist will operate in a similar way to the therapist they saw under Better Access. Presumably there is not even a guarantee that the client will actually get to see a psychologist and may be treated by a social worker or other professional. Having to transfer from one program to another is highly disruptive in therapy and not economically sensible.

Some clients may be referred to Better Access first because the referring GP was not aware of some of the client's issues or of the complexity of the issues. Hence large number of clients will be faced with having to switch programs midway through therapy.

Secondly, many will find it stigmatising to be classified as being too unwell to be seen by a private psychologist, thereby necessitating a referral to a team-based program. The Better Access program, which is situated at the primary health end of the health care spectrum, has enabled access to psychological services in a less stigmatising manner. Furthermore, clients were given a real choice as to who they consulted. If they did not feel that they were benefiting sufficiently from seeing a particular therapist they could choose to see another therapist. There will not be this degree of choice under ATAPS. Better Access has been a shift away from the more stigmatising public mental health services, which are generally staffed by psychiatrists, mental health nurses, social workers, occupational therapists and so on. Most clients do not need or want these services. It appears that ATAPS will shift clients back into a similar system with a team-based approach.

Thirdly, the current 2010/2011 ATAPS guidelines set by the Department of Health and Ageing states that "ATAPS in its current form is particularly suitable for providing short term psychological services to individuals with mild to moderate common mental illness". It is not clear how this program will now be able to cater for those with severe mental health issues who will no longer be able to obtain services under Better Access.

Fourthly, the ability of ATAPS to provide adequate services to this group of clients is highly questionable.

In addition to working in private practice and in the public mental health services, including drug and alcohol services, I have also worked part-time for one of the South Australian Divisions of General Practice in the Better Outcomes in Mental Health (BOMH) ATAPS program. This program mainly employed social workers and nurses who had undertaken some additional training in cognitive-behavioural therapy. The training and experience of these professionals was not adequate to address the needs of clients with more severe symptoms and complex issues. An examination of the current ATAPS guidelines suggests that this is still the case. I refer to pages 31 to 34 of the Guidelines, and in particular the table below titled '*Proforma for judging skills'*, which outlines the criteria that Divisions can use to assess the skill level of allied health professionals. This does not compare favourably with skill level of psychologists, especially those with clinical psychology qualifications.

APPLICATION FOR ALLIED HEALTH PROFESSIONAL TO PROVIDE SERVICES UNDER THE *BETTER OUTCOMES IN MENTAL HEALTH CARE PROGRAM* REQUIREMENTS	**CRITERIA**	**EVIDENCE OF MEETING CRITERIA**
QUALIFICATIONS:	**State qualifications**	
Counselling	6 month course (26 hours)	Name course
Assessment and diagnosis	6 month course (26 hours)	Name course
Cognitive-behaviour therapy	12 month course (52 hours)	Name course
Registration		Registration number and body
Member of Professional		Association and grade of

Association		membership
Experience working in mental health	2 years minimum Supervised experience	Where Qualification of supervisor
Current position/Type of Clinical Practice	In mental health field	Where Position Range of patients
Status of Professional Development	On-going and relevant PD and/or supervision	List PD undertaken in last 2 years, and/or type of supervision

(http://www.gpv.org.au/files/downloadable_files/Programs/Mental%20Health/Better%20Outcomes/ATAPS%20Guidelines%20to%20June%202011.pdf)

The region in which I worked in BOMH serviced a low socioeconomic area with high rates of substance use disorders and personality disorders, particularly borderline personality disorder. Although the BOMH program was geared towards primarily treating anxiety and depression, it was not uncommon for clients with personality disorders to slip through. Generally speaking, cognitive behavioural therapy is not adequate to treat these disorders. Unless a therapist is appropriately trained to diagnosis such disorders, there is a risk that the client will be inaccurately diagnosed and then treated with inadequate or inappropriate therapies.

For example, clients with borderline personality disorder generally do not benefit from cognitive-behavioural therapy and other therapies such as Dialectical Behaviour Therapy are recommended. Unless there are substantial changes to ATAPS, the program will be employing the same groups of inadequately trained professionals but instead of confining them to treating clients with mild to moderate symptoms of anxiety and depression, they will now be seeing clients with complex presentations and co-morbid disorders for which they have little training to diagnose or treat.

In effect, these professionals with less training and experience will be taking over service provision for the most difficult clients and psychologists will be treating those with only milder symptoms, which appears to be nonsensical.

Unless ATAPS is staffed by a large number of the most highly skilled clinical psychologists (or other psychologists with demonstrated skills in treating clients with a wide variety of mental health disorders), which appears unlikely to be the case, it won't provide the quality of care needed by this group.

To quote recent correspondence from the Australian Psychological Society:

> *'no other discipline receives as advanced training across the lifespan and the entire spectrum of complexity, severity and range of mental health disorders as the Clinical Psychologist. Ours is the only "Allied Health" discipline whose entire postgraduate training is in the field of advanced evidence-based and scientifically-informed mental health assessment, diagnosis, case formulation, consultation, treatment, evaluation*

and research. As such, the Clinical Psychologist is frequently referred the most complex and severe mental health presentations.'

ATAPS is unlikely to attract highly skilled and experienced psychologists given that psychologists are generally very poorly remunerated in such programs, as was the case with the BOMH program. Hence the most likely scenario is that ATAPS will attract a small number of very junior psychologists who do not have the experience to treat those clients who have the most complex and severe symptoms. The remainder of the clinical staff will be comprised of other professionals who do not have the training to adequately assist the group of clients that ATAPS is being geared to service.

It makes no sense to provide a program that is staffed by the least qualified people to treat the most unwell clients, whilst leaving those with mild to moderate symptoms to be treated by the most qualified mental health professionals.

Furthermore, the revamped ATAPS seems to be adopting a similar model to the BOMH program but using the new Medicare Locals rather than the Divisions of General Practice, hence there will be significant wastage of funds due to the costly administrative component of the program. The funding that is absorbed in administrative costs could be much better used for direct service provision. The Better Access program does not have these wasteful administrative costs associated with it.

Of further concern is that the proposed changes are due to take place in November but I and my colleagues have not received any detailed information about it. We are unclear about where our local ATAPS program is, how it can be accessed, which client groups are able to receive a service, whether clients with certain diagnoses will be excluded and what the alternatives are for them, and so on. There has been no information about whether it will be able to cope with the large numbers of people who may need to access it after the Medicare cuts. Given that the APS estimates that up to 86,000 clients require more than ten therapy sessions in a single year, it begs the question as to whether ATAPS can fulfill this need.

If the Government wants to save money, it is most puzzling that it would take funding from a highly successful program such as Better Access whilst continuing to fund other expensive programs which do not have the same demonstrated effectiveness as Better Access.

Although funded under a separate budget, the enormously expensive school chaplains program is an example of this. Surely mental health funding should be spent on getting the most highly trained and relevant profession to provide services in the most cost effective manner. The costs to the community of inadequately treated mental health issues would far outweigh the mere $118.6 million in proposed savings over four years by cutting Better Access funding.

In my opinion, the Better Access program appears to tick all the boxes. Not only has it been demonstrated to provide high quality cost effective treatment for clients with mild, moderate and severe symptoms but it provides a real choice for clients to access a less stigmatising program. Therefore it would appear to make most sense to at least maintain the current maximum of 18 appointments available to clients rather than decreasing it. In fact it would

seem appropriate to increase the number of appointments available to clients with more severe mental health issues given that these clients are often not able to be fully treated within these constraints. This would still be a much more cost-effective means of providing treatment than clients being referred to vastly more expensive options such as private psychiatrists.

e (1) The two-tiered Medicare rebate system for psychologists

I understand that it has been suggested that there is no justification for a two-tiered system of rebate for psychologists. Whilst I do not wish to comment specifically on clinical versus generalist psychologists, this suggestion raises a number of concerns. It is not clear whether the suggestion is that all psychologists, regardless of qualifications and experience, should be paid at the lower rate or at the rate which psychologists who provide clinical psychology services are currently paid. If a decision is made to move from a two tiered to a one tiered system of rebate, adopting the lower rate, it would be not be viable for most clinical psychologists to continue to offer bulk billing services or affordable services for fee paying clients. This means that a large number of clients would miss out on a service altogether and the Better Access program will effectively become the 'Limited Access' program, available to only a small percentage of clients who are able to pay a substantial gap. This change would effectively dismantle the Better Access program and many psychologists would have no choice but to cease operating or to reduce their private practice. In South Australia there are very few employment opportunities for psychologists and the picture would be grim. Hence there would be adverse consequences to both clients and the livelihood of psychologists if the rebate for clinical psychologists is slashed. This issue is not simply about psychologists being self-serving, and the complexities of the issue need to be considered before making such a decision.

The current Medicare rebate paid to clinical psychologists is already almost $100 below the recommended APS rate for a sixty minute consultation ($218 versus $119.80). The APS recommended rate is calculated based on the costs of operating a private practice and the Medicare rebate is not. I do not know any clinical psychologists who are able to offer bulk-billed sessions for all of their clients, even though many of us would like to do this. I currently bulk-bill about 25% of my clients and charge a small gap to a further 20%. If I offered bulk billing services to a greater percentage of clients my practice would not be financially viable. Whilst in no way am I suggesting that the Medicare rebate should be increased to this amount, the current Medicare rebate for Clinical Psychology services is far from generous when taking into account the factors I have outlined below. Any reduction of the rebate would make service provision unviable for me and many others. I believe it is important that those who are involved in making decisions about the rebates, who are not psychologists and are not aware of how we operate, become aware of these factors.

<u>Unpaid work</u>

It is generally not viable to see more than five clients per day if a psychologist is keeping the comprehensive session notes that our profession requires of us, in addition to follow-up

telephone calls, and the reports that Medicare requires us to write to GPs after every six sessions (without any payment).

I have worked as a psychologist in a number of state government departments and two Commonwealth departments. The rule of thumb in each of these workplaces was that for every hour of face-to-face contact a further hour was required for preparation for sessions, writing comprehensive notes, making telephone calls, writing reports and so on. The same applied when I worked in the BOMH program. Hence it was expected that no more than five clients be seen in an eight-hour day. I, and many other psychologists, have continued with this practice and see a maximum of five clients per day in our private practices. This generally results in a ten hour working day for me, of which five hours are unpaid.

The reports that psychologists are required to write by Medicare after every six sessions can take from thirty minutes to an hour, and are expected to be provided without payment. Further, psychologists are often asked by clients to write letters of support for housing, legal matters and applications for the Centrelink disability support pension and so on. Unlike general practitioners and psychiatrists, very few of the reports written by psychologists attract any payment, with the exception of those requested by Workcover and some legal reports, and most clients cannot afford to pay for them.

Unlike salaried psychologists, those in private practice are not paid if clients cancel at short notice or simply do not attend, but we still have the same overheads. In my experience, clients on low incomes are much more likely to miss appointments due to illness, lack of transport, child-minding issues, crises and so on. Being based in a lower socio-economic area I have about 20% of appointments cancelled each week, usually at short notice.

Overheads

There are significant overheads involved in operating a private practice and my current overheads absorb about 25% of my income. This is not unusual. My rooms are based in a relatively low socioeconomic area and are far from extravagant. It is not financially viable for me to employ even a part-time receptionist.

Funding of leave

Unlike psychologists who are employed in the state public service or other organisations, psychologists in private practice have to fund all of their own sick leave, annual leave, long service leave and son on, and do not receive employer contributions to superannuation.

I know of a number of other psychologists in similar circumstances to myself but I will use my case to illustrate. I resigned from a permanent position in the state mental health service and moved to full-time private practice about three years ago. Because I choose to bulk-bill clients and keep gap payments low, my income, taking into account overheads and having to fund my own leave and superannuation, is no more than what I received as an employee of the state mental health service, even though I now work about 45 hours per week. Despite this I have no desire to return to such a demoralising work environment. I gain far greater job satisfaction from working with my clients according to their needs rather than within the unhelpful constraints of the mental health service, seeing them overcome disabling

symptoms and improving their lives. If the Medicare rebate for Clinical Psychology services is reduced it would have one of two outcomes.

Clinical psychologists would have to greatly increase the gap payments made by clients. I know of psychologists who provide Focused Psychological Strategies who charge gaps of up to $80 or even more, because it is not viable for them to operate on the Medicare rebate of $78.40. Hence many clients are now paying higher gaps to see psychologists using Focused Psychological Strategies than to see clinical psychologists using the Clinical Psychology item numbers. I charge a maximum gap of $40 but if the Medicare rebate is reduced I would be forced to charge similar gap fees. A reduction of the Medicare rebate for clinical psychologists would effectively price most clients out of a service. Surely this goes against the principles of the Better Access program.

If psychologists work in an area where it is not viable to charge higher gap fees, such as the area where I work, we would simply be out of business. A loss of access to highly experienced psychologists would not be of any benefit to the community.

Whilst I accept that there are problems with the Better Access program, and it has not adequately met the needs of some groups, there are better alternatives to slashing it. For example, it could be expanded so that clients in rural and remote areas have access via teleconferencing or even telephone. Incentives could be provided to psychologists who are willing to travel to rural areas such as consulting rooms provided free of charge and a travel allowance paid. If some low income earners have not been able to access bulk-billing services then perhaps the Medicare bulk-billing rebate needs to be increased to match the recommended Medicare fee. Psychologists providing Medicare services could be required to bulk-bill at least 10% of their clients in order to be eligible to continue to provide services under Medicare. There are numerous possibilities of improving access to services rather than slashing Better Access in favour of inferior and costly programs such as ATAPS.

I thank you for reading this submission and hope that it has been helpful.

Yours sincerely,

Elaine Smale
M Psych (Clinical)
Member, Australian Psychological Society