Case examples illustrating how the Australian community will save more than $1198 by retaining 18 Clinical Psychology sessions per year

Submission for the 22 June 2011 Senate Community Affairs Committee for inquiry and report into The Government's funding and administration of mental health services in Australia. This submission relates to the following terms of reference:

(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;
(d) services available for people with severe mental illness and the coordination of those services;
(e) (i) the two-tiered Medicare rebate system for psychologists,
(ii) workforce qualifications and training of psychologists,

Rose is a 52 year old woman with severe anxiety (agoraphobia, panic disorder, obsessive compulsive disorder and social anxiety). She has lived house-bound for the last ten years in her boarding-house room. Rose also suffers multiple co-morbid physical health problems which are deteriorating because she cannot attend medical appointments with the exception of her GP who works across the road. The receptionist calls her to say the doctor is ready.

Rose receives 18 sessions of CBT to address her panic disorder and is able to leave the house. She is then able to catch public transport and attend her medical appointments. This also allows her to take her grandchildren to school sometimes. By doing this, she frees her daughter to attend TAFE.

$1198 worth of sessions (the ten that are apparently not required) buys Rose, her daughter and her granddaughters a whole lot of future. The grandchildren no longer have to stay in Granny's little room; their mother can access education to join the workforce, they will no longer live in a non-working family and, most of all, they learn that it is never too late to take control of your life.

Rose never presented to community mental health and would not be considered a priority because she has a high prevalence disorder. She is not experiencing psychosis or delusions, she is not suicidal and she won't ever demand help but a failure to treat her effectively would prove very expensive in the long run if the community has to pick up the tab for two more generations disengaged from education and work.

But couldn't Rose get the help elsewhere? Rose has multiple disorders, has co-morbid physical conditions and her compliance with treatment is compromised. She has a high prevalence disorder not suitable for out-patient care. She needs ongoing, individual, bulk-billed services by a clinical psychologist. She has seen various professionals in the past who have assessed her and encouraged her to try different services but did not actually treat her anxiety so she stayed feeling unable to attend. Assessment and short term help increased her alienation and kept her thinking that she was beyond help. At the time of year she was referred, the ATAPS money had run out (the programme will run out sooner now because it needs to spread even thinner. In addition, it costs more administratively so the few dollars will result in fewer treatment hours).

Josh is 16 years old. He is bright, previously a top student but has failed nearly all of his subjects recently. He is referred by his GP for sleep problems and depression. His mother is a

'hands-off parent' who is more interested in her new partner. Josh has always been a role model to his 10 year old brother. The school has given Josh warnings but it hasn't changed his behaviour. The school chaplain said the problem was because Josh is confused about his sexuality. Josh says he is clear about his sexuality. He says his problem is that he lies awake at night worrying then can't get out of bed until 11am. He gets to school about 1pm having missed most of the day.

Josh attends 15 sessions of CBT for social anxiety with a clinical psychologist; he no longer spends so much time worrying, attends school on time and starts doing well again. He is able to give more time to his brother. The $599 worth of sessions (5 more than would be provided under the proposed changes) buys Josh, his brother and his mother a whole lot of future. He achieves the good grades he is capable of, remains united with his mother and brother and they all learn that it is never too late to change your life. A failure to treat him effectively would prove very expensive in the long run if his brother learns to disengage from education and the workforce.

Josh, like many others, is best serviced by a clinical psychologist. He has a moderate severity, high prevalence disorder but has been misdiagnosed. Those who are supposed to help him assumed sexuality was the issue because they didn't have the skills to conduct a diagnostic assessment. Clinical psychology is the only mental health discipline, apart from psychiatrists, whose entire accredited training is specifically focused in the field of evidence-based assessment, case formulation, diagnosis, and evaluated treatment of the full spectrum of lifespan mental health disorders across the full spectrum of complexity and severity.

Couldn't he get help elsewhere? No. Problems at school are not grounds for child and youth out-patient care, he seems OK to talk to and he is causing nobody (but himself) any trouble. At the time of year he was referred, ATAPS had no money and it will have even less now because it needs to spread across more patients and costs more administratively.

Cathie is a 42 year old mother of two. She is referred for depression which she has had since her childhood which was marked by abandonment and parental substance abuse. She has seen numerous counsellors and doctors over the years and continues to feel distressed much of the time. Clinical psychology assessment reveals she experiences panic disorder for which she has never been treated. After years of suffering she is able to feel better, better manage the complicated dynamics of her blended family, and she and enrols in tertiary study. She shows her teenage daughter (who is also exhibiting early symptoms of anxiety), and step daughter better ways of coping with stress. She improves communication with her partner and shows her family and friends that it is never too late to change her life. A failure to diagnose and treat her effectively would prove very expensive in the long run if her children grow up with a parent with uncontrolled panic disorder and modelling disengagement from the workforce.

Couldn't she get help elsewhere? No. She is not acute and requiring inpatient or outpatient care, there are no abuse or neglect grounds for family services to be involved and being on income support, she does not have the money to pay a gap fee. At the time of year she was referred, ATAPS had no money and it will have even less now because it needs to spread across more patients and costs more administratively.

Angie is a young woman in her early twenties. She has multiple diagnoses including depression, substance abuse disorder, autism, and Multiple Sclerosis. She is unemployed, lives at home with her mother and rarely goes out, preferring to chat on the internet. She was expelled from primary and high school and was home schooled for the majority of high

school due to behavioural problems. She has been assessed many times but, at 25, even though she has had problems all her life, a referral under the Better Access programme is the first time she has ever been offered ongoing psychological intervention to improve her symptoms and behaviour. CBT with clinical psychologist allows her to start to leave the house, attend a support group and enrol in study. Angie has fallen through the cracks for most of her life, she needs more than ten sessions of help.

Couldn't she get help elsewhere? No. Community mental health needs her to stop using drugs before they will help her. The substance abuse agencies need her to manage her psychiatric conditions before they will help her. She does not have the money to pay a gap fee.

Actually, there are loads of cracks you can fall through.
As a clinical psychologist in private practice I see people who are referred through Centrelink/CRS for help to address their psychological barriers to work, from insurance companies and Workcover to help the injured back to work, from community corrections to address the psychological aspects of their offending, from GPs who don't have the time for demanding and querulous patients, from frustrated parents of adolescents and from workers struggling to stay in the workforce due to their psychological disorders. Please don't knobble this service so that it can only fix those who can pay for the extra sessions.

Mental health is important

Mental disorders account for an estimated 11% of disease burden worldwide. The World Health Organisation (WHO) project that this will rise to 15% by 2020. The Australian Institute of Health and Welfare reported that mental illnesses are the largest single cause of disability in Australia, accounting for 24% of the burden of non-fatal disease (measured by total years of life lived with disability). Given the high and increasing economic burden of mental illness, cutting cost-effective, flexible and accessible treatments risks bigger costs later.

International literature shows that 15-20 sessions are necessary for the effective treatment of common mental health disorders[1]. The UK recommend between 14 and 20 sessions for most high prevalence disorders[2].

Restricting access to 10 sessions a year sets up a programme that hits the vulnerable the hardest and ignores the evidence. We don't risk giving children fewer vaccinations than recommended because some of them will have immunity without the full course, and we don't provide sewerage to one half of the street because that would mean an adequate service to half of the residents. Even if some average patients use less than 10 services, for relatively small savings, why deny the rest in favour of an inadequate and expensive alternative (ATAPS)?

The numbers stack up – Clinical Psychology works and is cost effective.

[1] The Australian Psychological Society (APS) literature review recommended: Adjustment Disorder = 14 sessions, Eating Disorders = 15-20 sessions, Phobic Disorders = 12 sessions, Generalised Anxiety Disorder = 14 sessions, Panic Disorder = 7-14 sessions, Obsessive-Compulsive Disorder = 12 sessions, Major Depressive Disorder = 16 sessions, Drug and/or Alcohol Disorders = 52 sessions.

[2] National Clinical Practice Guidelines as established by NICE (National Institute Clinical Excellence, UK; 2005) recommends 8-12 sessions for Posttraumatic Stress Disorder, 12-15 sessions for Generalised Anxiety Disorder, 7-14 sessions for Panic Disorder and 16-20 sessions for Major Depressive Disorder.

The Federal Government's evaluation of the 'Better Access Initiative' has shown it to be a cost-effective way of delivering mental health care. The typical cost of a package of care – significantly less than ATAPS which costs from 2-10 times that the 'Better Access Initiative'.

The ATAPS program is not a viable referral option under current arrangements. Despite a planned doubling of the ATAPS funding, the money appears to try and spread what is needed for one year over five years. There is simply not enough to provide services for the estimated 86,000 per annum. Why spend limited money on a more administratively expensive arrangement?

The proposition that individuals who require more than 10 sessions of psychological treatment consult a psychiatrist is unrealistic. Most psychiatrists do not have the time to offer psychological treatments, and Rose, Josh, Cathie and Angie, all on income support could not afford prohibitive gap fees (up to $200 per session).

Two-tied funding provides the incentive to meet international standards and retains skilled workers

Clinical Psychology training is considered a minimum requirement to treat psychological disorders in comparable developed counties (eg. UK, NZ, USA, Canada). Clinical Psychologists seek to have all Australian psychologists able to offer a standard of service comparable to other countries. Without the two tier funding model we lose the incentive for psychologists to complete the years of study and pay the thousands of dollars in fees to obtain postgraduate clinical qualifications. This would result in the Australian psychological workforce possessing below par qualifications comparable to UK, NZ, USA, and Canada. This would lower the standard of care and would ultimately lead to qualified psychologists leaving Australia.

PLEASE, DONT GO BACK TO THE DAYS BEFORE BETTER ACCESS WHERE ONLY THE PSYCHOTIC, THE SUICIDAL AND THE WEALTHY GOT BETTER. THE COMMUNITY GAINS SO MUCH MORE BY HELPING THOSE WHO ARE MOTIVATED TO ASK FOR HELP!