

July 26th, 2011

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

Re: Government proposal to cut the 'Better Access to Mental Health Initiative' to 10 sessions. community.affairs.sen@aph.gov.au

Dear Senator Fierravanti-Wells, Senator Siewert and Members of the Senate Standing Committee on Community Affairs,

I am writing to express my objection to the proposed changes to the *Better Access to Mental Health Care Initiative* ('BOMH') as announced in the 2011 Federal Budget. The BOMH has been an effective community located and community specific prevention program. It has facilitated not only greater access to psychological services, but also a high degree of client choice, autonomy and anonymity in choice of provider and in service provision. This initiative has achieved world class results – not only in clinical outcomes but in low cost implementation, ease of access and public response and uptake. It would be a shame for Australia to abandon her position at the leading edge of developing a gold standard for mental health service provision when, according to World Health projections, this area will be one of the greatest health foci in the century to come. In this document I would specifically like to address the clinical and educational implications of cutting the yearly maximum allowance of psychological treatment from 18 to **10** sessions and of withdrawing financial remuneration for clinicians who have completed advanced training at Masters and Doctoral levels.

Relevant Expertise

I draw my observations from significant clinical experience, my own professional training (MA; Phd Psychology; Clin Dip Hypnosis) and the vantage point of an academic with over a decade of experience in designing and administering advanced training at undergraduate and postgraduate levels. I have constructed programs designed specifically to foster advanced psychological expertise and held research positions as Senior Research Fellow and Senior Lecturer in Psychology and Public Health. During my tenure I concurrently maintained a diverse clinical case load in private practice. I have supervised doctoral and masters students in clinical domains as varied as Aboriginal Experience of Severe Mental Illness, Anxiety Treatment, Cancer Survival and Cross-Cultural Rehabilitation. I was a member of the Curtin Public Health Postgraduate Research Committee and of the Curtin/Cancer Council HIV/AIDS Indigenous Health Research Committee. Since 2006 I have been the International Regional Coordinator for the Australia, New Zealand and Pacific Region of Division 27 of the American Psychological Association. This position requires ongoing reporting and feedback to the APA, coordination of all members within this domain, monitoring of professional conduct and provision of professional development programs.

My clinical work covers the range of DSM-IV statistical criteria and Medicare reporting obligations. As a practitioner within a prominent medical clinic in Western Australia I worked within a multi-disciplinary context which required effective collaboration and communication

with General Practitioners, Psychiatrists and a range of mental health professionals. My clinical work continues to be conducted in liaison with public mental health services and other community service providers. I provide professional and clinical supervision of staff and of Masters students on placement and have been involved in project evaluations, strategic planning and ongoing practice monitoring and evaluation for continuous improvement of best practice models.

I have numerous publications in refereed journals. Some of my reports have been tabled in the Western Australian Parliament as part of the State enquiry while others have been used in the development of State Health Policy. I was invited to be a member of the State “Child Health and Youth Clinical Network” advisory team to the Health Minister and also asked to be involved in the construction of *The Western Australian Perinatal Strategic Plan*. My writing has been published by UNESCO in their International Journal of Social Science as part of a global best practice review. I have been reviewer for the Australian New Zealand Journal of Public Health, the Journal of Community and Social Psychology and the E-Journal of Rural and Remote Health. In short, I have a substantial body of clinical and academic work to back the assertions I make in this submission and would be most appreciative of your consideration of these assertions as you consider the Better Outcomes for Mental Health initiative. I thank you in advance for your time and consideration.

Proposed Cuts to the Better Access for Mental Health Initiative

Firstly, I would like to draw your attention to some fallacious assumptions upon which the cutbacks to the BOMH initiative have been proposed. The first error is the assumption that the proposed changes to public services will be sufficient to not only treat the *current* population of those diagnosed with severe disorders but also to treat those in the moderate to severe band. The second error is the assumption is that ten Medicare sessions provide sufficient treatment for those in the moderate to severe spectrum and can prevent their slide into the former population. The third error made has been the assumption that the BOMH has not been a cost-effective population based approach.

In response to the first assumption: It is important to recognize that the proposed expansions to the public system are directed towards the current *deficit* of appropriate services. The increases, while helpful, will still not address the volume of clients who require intensive and lengthy treatment for severe spectrum disorders. Even with proposed system expansions Psychiatrists, ATAPS and other service providers will struggle to provide the number of treatment sessions required to effectively treat the volume of clients at the severe level. This situation is compounded by the reality that many of those desperately in need of treatment have had years of inadequate or intermittent treatment of severe disorders. With the proposed changes, people exhibiting moderate to severe symptoms who, through BOMH access, have been continuing to function in full time roles in paid employment or unpaid work will be left without access to adequate treatment. We then risk losing the capacity and productive contributions of *this* cohort to the economy. This cohort will almost certainly be without access to the treatment options which can treat their current episode *to the point of symptom remission*, and prevent slide towards the more severe end of the spectrum.

It is important to understand that the allocation of clinical treatment for an episode must provide a full course of treatment for that episode. Incomplete treatment risks relapse causing not only the pain of returned symptoms for the individual but the distress of more severe symptoms. Psychological treatment is similar to a course of antibiotics in that interrupted or

incomplete administration can result in developing resistant symptoms that then require a longer course of treatment. This is the clinical risk of cutting services back to ten sessions.

Presuming no co-morbidities; symptoms from a single episode of moderate to severe depression or anxiety often manifest for 6 to 12 months. Under the proposed cutbacks, this would leave clients with only two treatment options for such an episode: (a.) one session per month over the year or (b.) six weekly sessions over a two month period with a four week lapse until one month's additional sessions can be authorized. Neither of these options is appropriate for treatment at these levels of severity. The one hour per month option cannot contain symptoms or produce remission for moderate to severe cases. The "6 hours in 6 weeks" notion is inadequate to treat entrenched behavioural effects. Clients who choose the six week option and have a relapse would have no treatment option for almost a year.

Remuneration for Additional Tertiary Training: The Two Tier System

The second issue I would like to address is the two tier rebate structure. In effect this is a question of whether there is any difference between four years of tertiary level training and six years. Remuneration acknowledges the value of, and socially legitimizes, specialized tertiary training across all professional fields. Surgeons and Psychiatrists who complete degrees on top of their medical undergraduate command a higher fee than their colleagues with less tertiary training. Across fields, professionals who complete postgraduate training at the tertiary level command a fee that recognizes the value of said training. The very assumption behind Masters and Postgraduate level training is that it demands and develops additional skills. If the government refuses to remunerate or recognize the value of postgraduate level degrees that it is also responsible to legitimate it will have great difficulty rationalizing the public funds invested in, and the income garnered from, said programs.

The purpose of Masters and Doctoral level programs is to develop additional levels of skill and specialization in the current and future workforce of Australia. Extra years of rigorous, government certified, Masters and Doctoral level cost students \$20-\$60 000 per annum in educational fees and lost earnings. Additionally, a significant financial investment is being made for each student by Australian taxpayers. If the committee and the government decide that postgraduate training produces no increased skill or capacity it will be difficult to rationalize government role in funding and legitimating said programs, or, indeed, accepting fees from citizens. The assumption upon which this public investment is made is that postgraduate education has value not only to the individual but to the Australian workforce and to the Australian economy. Across professions, this is the rationale for the increased earning capacity of postgraduate trained individuals.

On what basis does the government single out psychology as a profession to which this does not apply? The statement that postgraduate training in the field of psychology develops no skills worthy of remuneration, particularly when such a statement is made and backed by the Federal government in the form of benefits paid, can only result in the eventual demise of psychology postgraduate programs. Governments, and indeed any employer, cannot expect individuals to invest \$40-\$100 000 in training and loss of income (based on a two year degree) to develop additional skills which are neither recognized nor remunerated.

Funding, Services and Access for Disadvantaged Groups

Disadvantaged groups face systemic and institutional oppression as well as individual disadvantage. Individuals from Indigenous and CALD groups may be especially reluctant to access services through public systems in which they, or those of their kin or culture, have currently or historically experienced oppression or abuse. The Public Mental Health system is no exception. The advantage of the BOMH plan is that it has enabled individuals to utilize an individually tailored and chosen 'port of access' for mental health services: their General Practitioner. Those who are differently-abled are also usually linked to the health system through the 'hub' of their GP. While many CALD and Indigenous individuals may avoid systemic engagement because of the multiple contextual barriers to system utilization they are usually be linked to a General Practitioner in their local community.

Barriers such as limited travel options, systemic alienation and information barriers are often overcome by the personal interface with a local, community based GP. The excellent uptake of the BOMH program has, in part, been facilitated by the fact that the GP provides an accessible, community located referral port for local providers of psychological services. This has contributed to the excellent BOMH results in preventing deterioration into more severe spectrum disorders. Facilitating ease of access to psychological services, within a context which maintains anonymity and personalized service, has resulted in a high client uptake of services. Psychologists should not be penalized for the success of the initiative. The fact that clients can, in consultation with their GP, "hire and fire" service providers encourages practice excellence and ensures psychologists maintain a client centred treatment approach. If there was low service uptake or poor client outcome cutbacks could be justified but given the excellent treatment outcomes of the BOMH such cutbacks can only lead to the 'penny saved and dollar wasted' outcomes of lost prevention opportunity.

I encourage the committee to consider the high degree of client choice, autonomy and anonymity facilitated by the BOMH program in its current structure of providing services. I would posit that the excellent uptake is linked to the effectiveness of the BOMH as it was designed. Unlike some services, psychological services require a high degree of privacy and client choice in order for treatment to have optimal effects. Anonymity of service uptake, ease of access and affordability are all critical factors in effective treatment of psychological symptoms in order to prevent the severe, costly episodes which are the greatest drain on the public purse. The BOMH has proven itself as a cost effective, community located service provision approach which is not only treating but preventing and reducing the long term burden of psychological disorders. In the interests of the health of the Australian population, economy and public purse I urge you to foster and strengthen rather than cutback this initiative.

Sincerely,

Dr. Katie Thomas