

Commonwealth Funding and Administration of Mental Health Services

Senate Inquiry: Community Affairs References Committee

To whom it may concern;

In regard to proposed changes in terms of Commonwealth Funding and Administration of Mental Health Services, I write to outline my concerns.

Of concern is the reduction of the number of sessions provided under the Better Access scheme from a maximum of 18 to 10. It is unclear on what basis the decision was made to reduce the number of psychology treatment sessions that a person with a mental health disorder is eligible under the scheme. No evidence base supporting the reduction in number of sessions was provided. It appears to simply be an administrative decision in order to reduce costs without understanding the impact on service provision and on clients that this will have.

Many of the evidence based interventions employed by psychologists require more than 10 sessions. I note, for example, that Cognitive Behavioural Treatments (CBT) for depression, PTSD, panic disorder and agoraphobia (to name a few) take up to 15 sessions. When personality variables are involved – such as when individuals have diagnoses of Borderline Personality Disorder (BPD) – this number increases. Indeed, the UK's NICE clinical guidelines for BPD, for example, discourage the commencement of a therapeutic relationship for duration of less than 6 months, otherwise the interaction could be potentially damaging to the patient (e.g. abandonment experience, increased risk of self harm and suicide). The fact is that six or ten sessions are often not enough to carry out a proper intervention – especially when best practice suggests comprehensive assessment (which could take two or more of these sessions). It may be enough to provide some psycho education about cognition, and/or a 'burst' of supportive counselling, which I suppose is a bit like gaffer-taping the patient up and sending them back on their way or giving someone with an aneurism an aspirin to cure their headache. It's not psychological treatment; it's a brief therapeutic intervention (in fact more like ATAPS than Better Access). Expecting people to be 'cured' of their anxiety or depression after 6 (or 10) visits is not all that different to expecting them to be 'cured' after six months of antidepressant medication. The symptoms may be addressed in the short term, but other factors that contribute to the illness are not. This means that relapse is increasingly likely to occur and that this will incur additional costs (financial, personal and social).

The reduction in the number of services provided under the Better Access program will affect approximately 86,000 people with more severe mental health problems, transferring them to the ATAPS program that is restricted to the provision of Focused Psychological Strategies that are not sufficient for more severe presentations; to private psychiatrists, of

whom there are insufficient numbers, and who charge high co-payments; or the public health system, that caters only to the most severe and persistent presentations. In WA (where I live) we have had a good public mental health system, but the current state government is taking away public sector roles and devolving services to the private sector where services can be provided at lesser cost. This is sleight of hand: post grad clinical psychs provided in the public sector are replaced by counsellors (less well trained, less qualified) in the private sector. What that means for mental health patients is that lesser agencies will get the funding (for example church and the like) and these do not employ post grad clinical psychs. Thus access to Clinical Psychologists is restricted. So what appears to be proposed is that the federal government is to roll back the policy from a previous government whilst a (Liberal) State government pursues the privatising agenda of the previous federal government. The end result is services and choices stripped from mental health patients from both ends.

Whilst this is occurring the public are increasingly at risk in terms of service reduction and quality control. People can't access the public system – because they are not “ill enough” – and can't get into the Better Access system – because they can't afford to pay for additional sessions that are likely to be required once they run out of rebated sessions. This doesn't for one moment consider what could happen if the individual is referred to someone without sufficient training and experience.

This leads to concerns about the possibility that the existing two tiered system within Better Access could be dismantled. The two-tiered Medicare rebate system needs to be retained as it recognises the value of accredited post-graduate training and specialisation in clinical psychology. State and federal awards differentiate between clinical and other psychologists and identify the differences in skill sets and the kind of work done by the two groups. I am concerned that there are interest groups within the profession that are minimising this difference in order – it appears to me - to further their own agendas. Simply being “a psychologist” is not enough. Undergraduate training programs in psychology don't do much more than provide overviews of psychological theory. There are no placements, no practicums – this happens at Master's level. Being supervised to obtain registration has, in the past, raised issues of quality control. To me it still does, even with the PBA creating some structures to ensure competence. The advent of Better Access has meant that individuals without comprehensive clinical training (and, in many cases, experience) have taken to working with individuals presenting with moderate to severe mental health issues in order to make a buck. I wonder what effect this has had on the cost of the Better Access program over the years.

I also note that the 2011-2012 Budget transferred funding from the provision of private psychological services for all age groups and levels of severity of mental illness, into public sector child and youth mental health programs for the most severely affected. Whilst I can applaud this – early intervention and prevention have definite benefits – I am concerned about robbing Peter to pay Paul. Australia has a greying population – something that also poses significant health care issues and not just in terms of mental health – and the lack of

funding for public services in this area (and reduction in funding to the private sector) is a concern.

In conclusion, I am concerned that reducing the number of sessions, removing the two tiered system, and transferring funding will adversely impact upon mental health consumers and the provision of mental health services at both a private and public level.

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