

Senate Enquiry - Commonwealth Funding and Administration of Mental Health Services

Submission by Ms Jillian Harrington, Psychologist

I am a psychologist, registered as a provider under Better Access, providing psychological treatment to clients in Penrith, Western Sydney. While I am a generalist psychologist, I have completed all coursework and practicum components of a Masters Degree in Clinical Psychology (with only the thesis remaining). As the director of a large group practice, I am also an employer and supervisor of both Generalist and Specialist Clinical Psychologists, who provide services under the Better Access Initiative. My practice includes the supervision of several other psychologists (both Clinical and Registered), who provide services under Better Access. I also sit on the local Division of General Practice ATAPS steering/advisory committee, and have been actively involved in provision of ATAPS services across three different divisions of General Practice, since the inception of the Better Outcomes Initiative (pre-dating Better Access).

I wish to submit the following comments in relation to selected terms of reference for this enquiry:

(a) the Government's 2011-12 Budget changes relating to mental health;

I applaud the government's investment of further funding into mental health, and consider the additional investments outlined in the 2011-12 Budget, a good start. I am disappointed that what looks like new funding, has come at the expense of diluting a very efficient, cost-effective and clinically valid system by reducing Better Access funding (see below). Increased funding of ATAPS, especially through Tier 3, is, I believe a useful and necessary strategy to address the mental health needs of the target groups for most ATAPS programmes. These are, by and large, DIFFERENT populations (both demographically and clinically) to those patients accessing treatment via the Better Access rebates.

The Budget's broad-stroke approach in addressing the various sequelae of mental health conditions (through funding programmes like PHAMS, and ATAPS Tier 3), appears to be wholistic and is welcomed. This should NOT, however, come at the expense of funding actual treatment services, which aid in clinical recovery, over and above just helping people to live or cope better with illness. As this funding is rolled out (especially ATAPS Tier 3), care should be taken that the targetting of specific groups (those seen to have missed out on help through Better Access to date), does not come at the expense of treatment services for others in our community who are genuinely in need of mental health treatment, either through Better Access, or through ATAPS Tier 1 programmes.

The focus on new funding for low prevalence, severe disorders (psychosis, bipolar disorder) is a little alarming, when this appears to come at the expense of effective treatment for much more common (and at times, equally debilitating) conditions like depression, the range of anxiety disorders, and complex trauma / personality disorder.

(b) changes to the Better Access Initiative, including:

(i) the rationalisation of general practitioner (GP) mental health services,

In psychology, a thorough clinical assessment, which informs treatment planning and implementation, and establishment of a sound therapeutic relationship (through the assessment process), lie at the core of every effective treatment outcome achieved. We can no more provide effective treatment without a good assessment, as can an orthopaedic surgeon undertake surgical intervention without the benefit of scans or x-rays! Given the fundamental importance of a good clinical assessment for good clinical outcomes, it seems duplicitous and wasteful to me, to require a referring GP to provide any other assessment than a diagnosis, to establish that the patient meets criteria for an ICD-10 diagnosis (and therefore for services under Better Access). The development of GP Mental Health assessments and Care Plans takes up, in my opinion, an inordinate proportion of Mental Health Funding. *When* we, as treating practitioners, are provided with copies of these plans (in only around 30% of cases), they are almost always clinically irrelevant, as we will ALWAYS undertake our own assessment before providing treatment. Would we ask a GP to "have a go" at assessing someone's heart condition in detail prior to referral to a cardiologist? I think not! I'm sure the majority of our patients would prefer for their GP to establish that they meet diagnostic criteria for a Mental Health condition, and simply refer on, allowing the patient to be funded for extra psychology sessions, rather than having the Mental Health Plan funded, and having to tell various aspects of their often painful histories, twice!

(ii) the rationalisation of allied health treatment sessions,

For the majority of patients with moderate to severe depression or anxiety (those most commonly seen under Better Access), 10 sessions of psychological treatment per calendar year, will be inadequate to treat their conditions. The low prevalence disorders championed in the Australian media and political climate with such aplomb in recent years, are NOT the only disorders which result in severe disability or impact!

We had a thriving private practice prior to the introduction of Better Access, and the type of clinical problems we see has not changed significantly since its advent. What HAS changed, is that the following groups can now much more readily access treatment services:

- People on low incomes (the “working poor” who may not qualify for ATAPS Tier 1, but are unable to afford private treatment without subsidy or rebate)
- Young adults who still live at home and are socially, but not financially, independent
- Women who are living with domestic violence and, while financially well-off on paper, have limited access to money for treatment or support
- People with anxiety disorders or depression where avoidance (of confronting the problem) is a primary feature, who had previously seen the financial cost as a valid reason not to seek treatment
- People with personality disorders (almost always survivors of early childhood abuse or neglect), who suffer from ICD-10 conditions at a much higher rate than the general population.

These are people who genuinely require psychological treatment, for moderate to severe mental health disorders. They could not afford such treatment without Medicare rebates. Treatment under Better Access very often, for these clients, makes the difference between being unable to work because of symptoms, and being able to participate actively in the workforce, with all of the benefits that this then brings, for the patients as well as for the community at large. Treatment under Better Access sometimes means the difference between being a good parent, able to function in a stable, emotionally responsive way, as opposed to being debilitated by symptoms of depression or anxiety, unable to respond to their children’s needs. In this regard, every dollar spent in Better Access treatment for a parent (of children at any age, not just in the perinatal period), comes back twentyfold (at least) in savings on the mental health needs of their children, for decades into the future. In today’s economic climate, not many areas of investment can offer such consistently reliable (alas, albeit largely unseen) return!

Most importantly for the last group mentioned above, who have already endured sometimes unimaginable trials in childhood, treatment under Better Access means the difference between living and dying – suicide in this group is an ever-present risk. This group is almost completely excluded from our public health system, with no services in most areas for those with a Personality Disorder (PD) diagnosis, apart from acute care when they attempt self-harm or suicide. This group are particularly disadvantaged by the cuts to Better Access rebates – we know that psychological treatment is pretty much the only effective way to treat personality disorders (and/or the plethora of ICD-10 Mental Health Disorders and co-morbidities they entail). We also know that such treatment, while it needs to be long term and intensive, is cost-effective, reducing the strain placed on public health and the hospital system by such patients, and allowing them to be active participants in the workforce, also reducing involvement in criminal justice, family law and child protection systems. While we can (at a stretch, and often with several *pro bono* consultations thrown in!) manage treatment for such a client at 18 sessions per year, to do so with 10 sessions would be not only clinically impossible but borders on unethical. To engage in short-term therapeutic work with these clients often makes their symptoms worse, not better, echoing previous experiences of abandonment and loss, and also echoing the failings of a “system” that doesn’t care enough to protect them or meet their basic healthcare needs.

Overall, in our practice, and those with which I am familiar, the Better Access initiative has been an incredibly useful, and necessary component in restoring mental health to many thousands of Australians who would otherwise still be unwell. The programme works, is cost effective and much-needed. The budget blow-out in the first 5 years has, in my opinion, been driven by an initial underestimate of the need, not by over-servicing or by therapy being provided to “the worried well”! Better Access is a much-needed initiative that places Australia at the forefront of Mental Health Service delivery internationally – we should be growing it, not cutting it back!

(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;

See above

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

ATAPS (Tier One) has been a necessary and helpful adjunct to Better Access, for Australians who cannot afford the gap payments usually required to see a psychologist in private practice, and for whom our community health and hospital systems provide inadequate care. With MUCH higher administrative costs associated with service delivery under ATAPS, than by private practitioners, increased funding of ATAPS (with the idea that this will, in a capped way, pick up the “slack” left by rationalising Better Access), will see a diluting of services available to those who need them.

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- (e) mental health workforce issues, including:**
(i) the two-tiered Medicare rebate system for psychologists,

Given the experience in our practice, with most patients using at least 12 session rebates under Better Access, and many qualifying for (and utilising) 18, I was surprised to learn that the median number of sessions identified in the Better Access review, was 5. One possibility accounting for this is the provision of Medicare provider numbers to any registered psychologist, regardless of mental health-specific training or experience. The Better Access initiative, while a great thing for patients with Mental Health disorders, has seen an influx of psychologists into independent private practice, who would otherwise be working in other areas (disability, organisational psychology, human resources, education), or who would otherwise be working under much closer supervision. Many such psychologists work in sole practice, often in a medical centre (employed by, or renting from, GPs who refer to them – and who therefore benefit financially from the referral – surely a conflict of interest?). They often work with little or no supervision (peer consultation if any), without the checks and balances that may be in place in a setting where psychologists and clinical psychologists, trained and experienced in mental health treatment operate independently of referring doctors. For the vast majority of patients presenting under Better Access, a manualised approach to treatment – providing Focussed Psychological Strategies as per a treatment manual, without undertaking a thorough assessment, formulation, and tailoring strategies to meet the individual client's needs, is ineffective. I wonder whether the median figure of 5 sessions reflects that patients seeing such practitioners tire of the process, find it less-than helpful, and just stop coming before their course of treatment is complete?

Having worked in mental health as both a generalist psychologist with no clinical psychology training, and as one who has all-but completed such training, I agree that Clinical Psychologists bring to their work a range of skills and a scientist-practitioner perspective which is, sadly, not universally seen in psychologists without post-graduate training. I believe that this distinction is, however, almost impossible for GP's to make. In our experience, no distinction is made by local GPs between referring patients to a clinical vs generalist psychologist. While I understand they should, (on paper at least) refer more complex, severe cases to clinical psychologists for clinical psychology services, while less severe presentations should be seen by generalist psychologists for Focussed Psychological Strategies, this is, in practice, a nonsense, and is neither reflected in GP referring patterns, psychologist workload, or patient outcome. Determining factors around referral choice are much more likely to be cost (a patient imperative), availability / waiting times, established referral networks, and specific clinical areas of interest or expertise.

I believe there is merit in the use of a higher rebate for those treating more complex and severe conditions, along with more clinical autonomy and flexibility to decide (within the scientist-practitioner model), on treatment modalities. The current system sees many very experienced, skilled and dedicated generalist psychologists, attracting a much lower rebate than a newly-graduated Clinical Psychologist, and I think this needs redressing. One idea would be the establishment of an independent assessment of some sort (examination, case studies, supervision logs), to enable highly proficient, skilled and experienced psychologists to demonstrate that they can provide a higher level of service OUTSIDE of the clinical psychology specialty pathway. All therapeutically relevant roads do not lead to APS Clinical College Membership!

Furthermore, I would argue for the establishment of a THIRD tier in the Better Access scheme, to allow for clinicians with the skills and experience necessary to treat severe, complex and pervasive conditions such as Personality Disorders and survivors of multiple or complex trauma. Such patients when seen in psychiatry, are able to access much more intensive and frequent treatment than those with less debilitating diagnoses. Perhaps, similarly to the way certain PBS prescriptions are available only to those with certain diagnoses, these very damaged and unwell Australians (who will be most disadvantaged under the Better Access cuts) could be seen by appropriately-credentialed psychologists and clinical psychologists (Tier 3), for treatment *at the right therapeutic dose*. The Literature at present would suggest that gold-standard treatment for these patients entails weekly to fortnightly treatment, for 2 – 5 years, but they DO get better!

- (ii) workforce qualifications and training of psychologists, and**

See (c) above.

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