Senate Inquiry into the Commonwealth Funding and Administration of Mental Health Services

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

27th July, 2011

Dear Senate Committee,

This submission relates to specific items under the Commonwealth Funding and Administration of Mental Health Services:

Changes to the Better Access Initiative (BAI)

(b) (ii) *the rationalisation of allied health treatment sessions*

The Mental Health Minister has stated in the 2011 Budget Paper No.2 that:

> "The new arrangements will ensure that the Better Access initiative [BAI] is more efficient and better targeted by limiting the number of services that patients with mild or moderate mental illness can receive, while patients with advanced mental illness are provided more appropriate treatment through programs such as the Government's Access to Allied Psychological Services program [ATAPS]".

The above assertions are based on the following false and misleading premises:

1) **That the BAI has not been effective**: yet evidence shows that thousands more patients with mental illness have now been able to access affordable and effective psychological treatment by making Medicare available for the first time. At least as well trained in psychotherapy as their psychiatry peers (and many more so), the inclusion of psychologists in Medicare funded providers has also freed up hundreds of GP services for patients presenting with more medical-related illnesses. Recent studies have confirmed the cost-effectiveness to the government of this BAI program. And, consistently, research over the

past 30 years has demonstrated, that the ongoing therapeutic relationship between therapist and patient is the most important therapeutic factor for bringing about improvement in mental illness, thus the necessity for sessions beyond the limit of 10, as proposed.

The majority of these patients do not have access to psychiatrists, either because there are insufficient available with specialist psychotherapy training (as with clinical psychologists who have very extensive training in psychotherapy), or because the fees are too high particularly for patients on disability pensions or those on low incomes. The current AMA recommended fee for psychiatrists is $305.00 per 45 minute session, of which only $176.00 is rebateable under Medicare. Treatment by clinical psychologists is therefore not only as clinically effective much more economical.

2) **That psychologists are working with only 'mild or moderate' mental illnesses**: this again is based on the misconception that current services provided are for short-term psychological treatment, where only a small number of sessions are required and for relatively mild psychological problems. This is not the case. Clinical psychologists, in particular, seldom treat patients with mild to moderate mental illness under the Medicare Benefits Schedule (see recent APS survey).

In order to gain evidence-based data, the BAI evaluation should have been conducted under rigorous research methodology but, instead, it did not meet any of the fundamental standards of a proper research designed model: it did not identify the nature, diagnosis or complexity of the clients seen by psychologists by type of psychologist (clinically trained or generalist); it did not identify the nature or type of psychological intervention actually provided; it did not factor in or out medication use by the client; it did not factor in or out therapy adherence indicators; it did not have a valid criterion measure actually related to a range of diagnoses or complexity in order to assess pre and post intervention condition of clients; it did not undertake follow-up assessment of clients, which is often the point at which the relative strength of any competent treatment becomes manifest; it did not determine relapse rates by type of psychologist (clinically trained or generalist).

3) **That ATAPS is the more appropriate treatment for patients with advanced mental illness**: this program which offers a team approach under the direction of the Division of

General Practitioners is not a suitable treatment model for ‘patients with advanced mental illness’ These patients present with serious mental illnesses such as borderline personality disorders, major depression, and severe anxiety disorders which encompass panic attacks or debilitating obsessive compulsive rituals, which can prevent even ‘normal’ daily functioning, Such patients require long-term, insight-oriented, psychotherapy as is offered by the highly qualified clinical psychologists, within the context of a trusting therapeutic relationship. Research over 30 decades has demonstrated that this relationship is the most important factor for providing the greatest improvement in mental health. Members of the Clinical College have attained the expertise and training to equip them for working with those patients who present with these serious mental illnesses

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(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*

These proposed changes will reduce the number of Medicare-rebated psychology sessions, in any one year, from 18 (12+ 6) to 10 (6+4). This reduction is based on the mis-conception that current services provided are for short-term psychological treatment, where only a small number of sessions are required and for relatively mild psychological problems. This is inaccurate and misleading. As mentioned earlier, clinical psychologists seldom treat patients with mild to moderate mental illness under the Medicare Benefits Schedule. The Mental Health Minister has unfortunately been ill-informed by his psychiatric advisers. Rather than reducing the number of sessions available in any one year the government would be well-advised to enable those patients with an enduring and debilitating mental disorder to access further Medicare rebates, so that their treatment is not arbitrarily ceased at a given time as if “one treatment fits all mental illness”. For clinical psychologists, needing the greater number of sessions because of the complexity of cases worked with, this raises a moral dilemma. Can we, in conscience, accept patients we know have no chance of recovery in the maximum 10 sessions proposed (or current 18)? We are aware that to stop treatment at that arbitrary point, and not because the patient is ready to leave, can do far more harm to the patient.

It is of note that psychiatrists have unlimited access to Medicare, under Item No 319 (even 5 x per week), to treat similar patients now referred to clinical psychologists, and all general psychiatrists with no additional psychotherapy training, can still access 50 sessions per year.

It has become much more difficult now for General Practitioners to find appropriately trained and affordable psychiatrists. Clinical psychologists are thus constantly receiving patients with borderline personality disorders, bipolar and other severe mood disorders, the serious and debilitating obsessive compulsive disorder, and even patients presenting with florid psychotic symptoms. Are we being asked to "cure" such patients in 10 sessions because we are seen as the experts? And if this is the case, why the need for unlimited, and more expensive, access to Medicare rebates for our psychiatry colleagues? This is a huge anomaly that hopefully the Senate Inquiry will address.

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Mental health workforce issues

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

With the introduction of the BAI a clear distinction was made between the more highly trained and skilled clinical psychologists and their generalist colleagues, who have not undertaken post-graduate university study and clinical training. A two tiered system was thus established enabling patients to access both groups through the BAI, but acknowledging the need for extra sessions by clinical psychologists who treat the more severe and complex mental disorders. This system also guides General Practitioners in the referral of patients according to their specific needs.

(e) (ii) *workforce qualifications and training of psychologists*

The Australian Psychological Society (APS) is the professional body for over 20,000 registered psychologists. Within this are nine specialty Colleges to which members can choose to belong by gaining further, extensive, post-registration training. Clinical College membership requires the successful completion, at university, of at least a Clinical Masters, but most members attain a Ph.D. These requirements are far in excess of the criteria for generalist psychologists, and include theoretical and practical training in the important areas of personality development and the assessment, diagnosis and treatment of psychopathology. The knowledge base of this training is built upon the principles of behavioral change, individual differences, abnormal behavior, the understanding of serious and complex mental disorders, and the professional and ethical concerns surrounding clinical practice. Conducting a major piece of research is also an essential component of clinical

training, plus the exploration of the different therapeutic modalities, which enable clinical psychologists to work within the range of treatments offered for the higher Medicare rebate.

If the further education and expertise of clinical psychologists is not recognized as a specialized psychological training there would be little to attract psychologists into spending many more years at university, and enduring personal financial hardship, in order to be better equipped to work with the serious mental disorders.

In conclusion, unless the government reverses its ill-advised decision to cut the Medicare rebates under the BAI, thousands of desperate patients, now receiving psychological treatment for the first time, will be thrown back into a dysfunctional public system and will be put at risk, with no continuity of treatment.

I sincerely hope that the Senate Committee will see the many financial and treatment gains of encouraging the government to retain such an important, and cost-effective, mental health initiative, and to consider the benefits of actually increasing the number of sessions beyond 18 for patients who require a longer-term treatment, which can potentially keep them in the workforce and out of hospital. I also hope that the significant two-tiered system will be maintained. This is so important if those patients with complex and serious mental health needs are to receive the most appropriate treatment from clinical psychologists, the practitioners who are best qualified to provide it.

Sincerely,

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