

Commonwealth Funding and Administration of Mental Health Services

Senate Inquiry: Community Affairs References Committee

I, Simon Baxter, Clinical Psychologist in private practice and consultant to public health (hospital & university clinics) based in Melbourne and Geelong would like to thank the Senate (Community Affairs Reference Committee) for the opportunity to address the issues raised in this inquiry.

I wish to argue with evidence-based research and practice-experienced knowledge according to the following reference terms of the Senate Inquiry:

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

(ii) the rationalisation of allied health treatment sessions

Mental health treatment in the community is headed for troubled waters. The Government's recent Budget has proposed reducing from 1 November 2011 the number of psychological therapy sessions available under the GP-referred Better Access Mental Health Treatment Plans. The consequence is a cut from a potential maximum of 18 sessions per calendar year down to just 10. It is unclear how this decision was made and no evidence supporting this decision has been demonstrated. The cut removes the present option of an extra 6 sessions (i.e., 13-18) for 'reason of exceptional circumstance'.

Psychologists have been wise to use this facility when patients are assessed with complex circumstances (unemployment, divorce, addictions & thoughts of suicide) or personality disorders. The rationalisation of allied health treatment sessions leaves many with chronic and/or serious mental health problems without adequate or appropriate services. The proposed cuts to Better Access are ill-considered and will harm community health and lead to direct and indirect cost blow-outs elsewhere.

Given Medicare Australia reports that 75 pct of GP Better Access Mental Health Treatment Plans are for a diagnosis of Depression, an argument based on standard depression treatment shall provide a suitable picture on how the mental health system will be damaged by the coming cuts to psychological therapy sessions eligible for Medicare rebate. A comprehensive research article published in 2009 described the findings of a Mood Matters project (Australian & New Zealand mental health services collaborated with the University of Sydney & University of Melbourne). The journal article titled 'Clinical practice recommendations for depression' (*Acta Psychiatrica Scandinavica*, 119, 8-26) resulted from a literature review of over 500 articles & clinical manuals to formulate the best treatment for depression.

The report concluded "The management of depression should be based on a combination of data-driven evidence and clinical experience", "Management strategies should be tailored to the individual so as to SET A PACE for treatment that matches the phase of the illness", "Consideration should be given to clinical context, potential co-morbidities and the quantification of symptom severity using rating scales", and finally "**Psychological strategies should be given greater consideration**". In terms of the SETAPACE assessment-formulation-treatment acronym, the basic outline is:

Safety

Education

Therapeutic Relationship

Assessment (of clinical factors to Characterise, Calibrate, Corroborate & Consider)

Psychological Therapy

Antidepressant treatment

Combination (of P & A)

ECT (electroconvulsive therapy)

The report authors outline a fairly standard therapeutic stepped model that most treating clinical psychologists would already be familiar with and practicing when treating patients diagnosed with depression. Treatments of last resort are kept in mind across therapy and include potential anti-depressants (if not already prescribed) and finally but rare-in-practice a psychiatric referral (potentially for ECT) for cases of severe, incapacitating and unyielding depression that fails to respond to standard psychological interventions.

Reductions to psychological therapy under Better Access will make psychiatric referrals (usually 6-month wait-lists) more common as psychologists screen and refer on the more complex or severely acute and chronic cases. Research and clinical evidence suggest around 30-40 percent of our patients meet criteria for co-morbid personality disorders and/or addictions impacting treatment efficacy and clinical outcome. Lowering session numbers (from 18 to 10) will deny many patients a sufficient dose of psychological treatment. Imagine going to the dentist to fix your diseased tooth, having a molar drill-cleaned out, prepared for filling, and then told "I'm sorry, that's all we can do this year, would you mind returning next calendar year and we shall conclude your treatment?" This is the awful dilemma facing psychologists for severe and complex cases seen in private practice. Predictably, the consequence will be upon the patient as they slide down the SETAPACE clinical guidelines towards psychiatric and pharmacological interventions, hospital admittance and perhaps electroconvulsive therapy. I forecast that if the changes to Better Access occur on 1 November that we shall see significantly greater use of PBS psychopharmacological medications, psychiatric hospital admissions, and ECT use over the coming years, if not immediately in 2012. In addition, social costs are more likely: divorce, unemployment, disability pensions, drug/alcohol abuse, family stress and suicide statistics. Clinical Psychologists regularly consult with one another de-identified case studies describing how such painful or calamitous situations were therapeutically minimised or halted.

Our ethical code demands we refer on psychology patients presenting with problems outside our expertise or stretching our psychological resources past the limit of competent capacity. If Better Access eliminates as-proposed the 'exceptional circumstances' provision allowing a maximum of 18 sessions per calendar year, and reduces the standard allocation from 12 to 10, then ethically we will be more inclined to refuse treatment requests with "I'm sorry, your complex condition cannot be adequately treated within 10 sessions - please return to your GP for a more appropriate referral". Obviously, those referral options will be chemist, psychiatrist & hospital.

I am currently treating patients who are adamant they will not take medications or consult a psychiatrist, believing psychological therapy will be sufficient for their needs – persuasive argument

rarely shifts their position. I caution such restrictive comments about other mental health interventions when assessing the presence of severe co-morbid and complex factors such as abuse, trauma, addiction or debilitating personality disorder. Most still refuse other treatment options. Severely incapacitated patients cannot afford to see me without Medicare rebates (whom I bulk-bill) and I will be compelled to close their file in late 2011. Where will they go? Consider the common presenting circumstances: often single, living alone, unemployed, battling addiction (alcohol/drug/porn/gambling etc.), overwhelmed by intrusive memories of trauma, and for one reason or another resistant and fearful of psychiatric treatment options. Given some years of experience in suicide prevention, I have witnessed people in tough situations often experiencing suicidal ideation attached to a deep psychological ache ... *I must escape from pain*. Sometimes the medication stops working. Shortly, Better Access will work far less too, leaving many at risk. A tragic irony exists when one considers the Minister for Health has bemoaned the poor representation of targeted young men accessing mental health services – this is my highest prevalence patient cohort.

The coming limits to Better Access are substantially taking the P (for Psychological therapy) out from the clinically-recommended SETAPACE model for the severely depressed. Clinical guidelines for prevalent evidence-based psychological treatment models (Cognitive-Behavioural, Interpersonal, & Short-Term Psychodynamic Psychotherapy etc.) all require more than 10 sessions (usual 15-25). I fear my private practice shall become less diverse, more consultative to the well-resourced, and scarce of severe cases to whom my specialist clinical psychology treatment skills and experience are most needed for reducing mental health symptoms, eliminating disorder, and improving occupational productivity and social functioning.

As psychological therapy covers most of SETAPACE model (i.e., Therapeutic relationship, Assessment, Combination of therapy with medication) just 3 acronym letters remain for treating the severe patients with co-morbidities who are refused access to Better Access after sessions are limited to ten in 2012. The remaining words are Safety, ECT and Antidepressants. A diminished Better Access will leave many depressed patients metaphorically adrift at SEA. Contrary to clinical recommendations, psychological therapy in private practice will in 2012 be given lesser consideration. How many will sink or swim? That estimate will plainly arrive with hindsight in 2013. Simply collate state-by-state 2012 data on emergency department consultations (for mental health), numbers receiving electroconvulsive therapy (e.g., Victorian Chief Psychiatrist recently reported that in 2010 1750 patients received ECT, including 83 children), psychiatric unit admissions, and use of PBS for psychopharmacological agents. I reckon if Better Access sessions are indeed cut, all these measures will increase dramatically for 2012 and beyond. In addition, the Health savings made through Better Access restriction will blow out the costs for expensive psychiatric interventions.

Reducing Better Access shall force many patients into a treatment regime that is coercive and isolating. Many patients I have encountered in psychiatric hospital units and in the psychology clinic often report “I am lonely”. Come 2012 with a less-than Better Access, the moderate-to-severe symptomatic patients shall be lonelier, exiled from face-to-face psychology before or after a mere 10 sessions, and left to slide down the clinical guidelines for depression towards medication and ECT.

In conclusion, I implore the Senate to not pass the proposed legislation “rationalising” psychology treatment services within the Better Access health initiative.

The following sections are actually copied from a provided draft-submission to the Senate Inquiry by the Australian Clinical Psychology Association (ACPA) that I, Simon Baxter, am a member of. I include some of their points within my submission as I wholly agree with & support their arguments.

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

(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

It is unclear on what basis the decision was made to reduce the number of psychology treatment sessions a person with a mental health disorder can receive each year under the Medicare Benefits Schedule from a maximum of 18 to 10. No evidence base supporting the reduction in number of sessions was provided. The Mental Health Expert Working group does not appear to be instrumental in guiding this decision. Indeed, the APS is undertaking a campaign against the proposed changes, despite being represented on this working group, as is the AMA and ACPA.

If the decisions were made on the basis of the Evaluation of the Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule (May, 2011) survey, this basis is fatally flawed. This survey does not meet the most basic and fundamental standards of research design for treatment outcome studies. It failed to: take a prospective approach, which is standard in outcome research; utilise an adequate sample size to ensure proper representation of service providers; identify the nature, diagnosis and complexity of the patients seen by psychologists with differing levels of training; identify the nature or type of psychological intervention that was, in fact, provided; control for adherence to treatment guidelines by providers or patient compliance; examine the role played by medication in outcome; have a valid criterion measure related to a broad range of diagnoses with inbuilt algorithms to account for severity and complexity of presentation; look at drop-out rates and the reasons for these; undertake follow-up evaluations; determine relapse rates by type of treatment type and by psychologist training; and it was not subjected to peer review. Furthermore, the evaluation used a self-selected sample of psychologists who then selected their own clients for the study, and administered the research questions in session.

This survey breached multiple research design guidelines for treatment outcome studies and therefore has limited validity or reliability. Furthermore, no recommendations were made by the authors of this survey to reduce the number of sessions patients received or to change policy to enable only mild-severe mental health problems to be treated under the Better Access Scheme. How this inadequate data was interpreted to arrive at the decisions made is unclear.

The most recent reported re-referral figure of 43% of patients under the Better Access Scheme, (September, 2009, Council of Australian Governments National Action Plan for Mental Health 2006-2011, Second Progress Report, covering implementation to 2007-08) points to the short-term benefit of short term treatment strategies. It suggests existing inadequacies in the level and/or nature of services provided under the Better Access program that were not identified in the Evaluation of the Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule (May, 2011) survey.

Nevertheless, the APS states,

The Government's own evaluation of Better Access demonstrated that it is a cost-effective way of delivering mental health care. The typical cost of a package of care delivered by a psychologist under the initiative is \$753, significantly less than ATAPS which costs from two to 10 times that of Better Access per session. Successful treatment also reduces costs of

hospital admissions and allows many consumers to return to work, with the associated productivity benefits. (APS, June 2011, Federal Budget cuts to the Better Access initiative Briefing Paper).

While this form of service delivery may be cost effective, it may not be clinically effective. What is required is a well-designed prospective study, grounded in the research base for outcome evaluations, and based on sound methodology. Such a study needs to generate specific hypotheses and select the appropriate methods and measures to provide evidence for or against these hypotheses.

The Government has argued that the changes to the Better Access Scheme will not affect large numbers of consumers, as only approximately 13% of Better Access patients receive more than 10 sessions. This, however, equates to around 86,000 (Lyn Littlefield, CEO, APS, LifeMatters 21/06/2011) patients per annum, all of whom are the more vulnerable amongst those with mental health problems. While the government states that these people may obtain services under the Access to Allied Psychological Services (ATAPS) program, the public health system, or from private psychiatrists, these options are not necessarily suitable for this group of patients and are exceedingly limited.

Apart from the fact that there has not been an adequate transfer of funding to the ATAPS program, this program is restricted to the provision of Focussed Psychological Strategies (FPS) that can be delivered by psychologists and other allied health professionals (2010-2011 Operational Guidelines for the Access to Allied Psychological Services Component of Better Outcomes in Mental Health Care Program, p. 5). Patients with more chronic or severe mental health problems require services provided by those with advanced knowledge of assessment, diagnosis, formulation and treatment modalities of mental health issues, such as clinical psychologists and psychiatrists, to ensure they receive more suitable evidence-based treatments tailored to their needs. These services are not provided for under ATAPS. Currently, to have those with more moderate and severe presentations treated under ATAPS, means to have the more vulnerable treated by a workforce that includes psychologists without specialist qualifications and training in mental health, utilising short-term strategies.

In their Federal Budget cuts to the Better Access initiative Briefing Paper (June, 2011), the APS states,

The ATAPS program run through the Divisions of General Practice (DGPs) is not a viable referral option under current arrangements. There is simply not enough funding in ATAPS to provide services for anything like the number of 260,000 people (or 86,000 per annum). A major issue is that a significant proportion of the funding for mental health services received by DGPs is spent on administration rather than providing funding to the psychologists who are engaged to deliver the services. As a result, frequently more junior psychologists are selected to provide services and more experienced psychologists cannot viably undertake the work. (p. 3).

Furthermore, there is a significant shortage of private psychiatrists. Only a very limited number of psychiatrists bulk bill patients, making treatment costly, particularly as most tend to charge high co-payments. There is a particular shortage of psychiatrists in low SES and rural areas.

The public health system only takes the most severe and persistent presentations, and again, the group of patients disadvantaged by the cutbacks in the number of sessions available under the Better Access program would not meet criteria for these services. This leaves patients with more chronic, moderate to severe mental health problems unable to access services.

We do, however, support the limitation of the number of sessions to ten for those psychologists and other health professionals without accredited post-graduate training in mental health, who provide Focussed Psychological Strategies based on the approaches developed by clinical psychologists. Focussed Psychological Strategies are limited in what they can achieve, particularly for the more chronic, moderate and severe presentations in mental health.

Recommendation:

Those patients who require more sessions than the number (ten) available under the changes to the Better Access Scheme need to be referred to clinical psychologists working in the private health system, but with access to the public health system where required, for assessment to determine the best available service for their level of difficulty or for longer term treatment. This is cost-effective and makes best use of the expertise of clinical psychologists.

(e) Mental health workforce issues, including:

(i) The two-tiered Medicare rebate system for psychologist

The two-tiered Medicare rebate system recognises the value of accredited post-graduate training in the speciality of clinical psychology for the provision of high quality services to those members of the public suffering from mental health problems. Qualified clinical psychologists are trained to be experts in the prevention, assessment, diagnosis, formulation, treatment, and evaluation of treatment outcomes for a wide range of mental health problems, at all levels of severity, across the lifespan. Only qualified clinical psychologists and psychiatrists have these levels of advanced training in mental health.

Skill levels of different psychologists within the workforce:

The Management Advisory Service to the National Health Scheme in Scotland differentiated the health care professions according to skill levels (Management Advisory Service (1989) Review of Clinical Psychology Services; Activities and Possible Models MAS, Cheltenham). Skills in this sense referred to knowledge, attitudes and values, as well as discrete activities in performing tasks. The group defined three levels of skills as follows:

Level 1- "Basic" Psychology - activities such as establishing, maintaining and supporting relationships; use of simple techniques (relaxation, counselling, stress management)

Level 2 - undertaking circumscribed psychological activities (e.g. behavioural modification). These activities may be described by protocol

Level 3 - Activities which require specialist psychological intervention, in circumstances where there are deep-rooted underlying influences, or which call for the discretionary capacity to draw on a multiple theoretical base, to devise an individually tailored strategy for a complex presenting problem. Flexibility to adapt and combine approaches is the key to competence at this level which comes from a broad, thorough and sophisticated understanding of the various psychological theories (p. 6).

The group suggested that almost all health care professionals use level 1 and 2 skills and some have well developed specialist training in level 2 activities.

The group went on to argue that clinical psychologists are the only professionals who operated at all three levels and, "it is the skills required for level 3 activities, entailing flexible and generic knowledge and application of psychology, which distinguishes clinical psychologists from other disciplines" (p. 6).

This is consistent with other reviews which suggest that what is unique about clinical psychologists is their ability to use theories and concepts from the discipline of psychology in a creative way to solve problems in clinical settings.

Clinical psychologists in the workforce:

The responsibilities of Clinical Psychologists have increased very considerably since the mid to late 1980's. Clinical psychology has, during this time, become more fully established as a profession which provides highly specialised and autonomous mental health services to individuals across all developmental stages. The profession provides specialist diagnostic and complete psychobiosocial assessments, treatment services in areas as complex and diverse as psychotic illness, severe personality disorders, comorbid disorders (e.g. depression within borderline personality disorder), psychological and behavioural components of serious medical conditions, and problems specific to different age groups, including recent significant developments within the areas of children and family, youth mental health, the elderly, mental health disorders within medical conditions, quality assurance and research and evaluation. (1998, Work Value Document, Western Australia Clinical Psychology Health Sector, p.317).

Clinical Psychology has also taken an increasing responsibility in the treatment of less prevalent mental disorders within the psychotic spectrum, bipolar disorder and the more intractable personality disorders. The roles and responsibilities of Clinical Psychologists have increased through the development of psychological therapies which address components of these disorders, and in specific psychological interventions targeting other mental disorders which are very often comorbid with psychotic conditions, such as depression, anxiety and substance use disorders. Along with providing treatments to these patients, Clinical Psychologists have been increasingly called on by Psychiatrists, to provide additional diagnostic information, to assist with differential diagnoses of complex cases (1998, Work Value Document, Western Australia Clinical Psychology Health Sector, p.18).

Another area of increased responsibility within Clinical Psychology is in the role of teaching and informing other professions of evidence-based development in treatment for mental health

disorders. Clinical Psychologists have a growing role in providing education and training to professionals including Medical Officers, Psychiatric Registrars, Mental Health Nurses and Social Workers. Areas in which Clinical Psychologists frequently contribute in this way include responding to suicidal and chronically self-harming individuals, and psychological treatment of depression, anxiety, social phobia, obsessive-compulsive disorder, eating disorders and substance use disorders. With the recent application of psychological therapies to disorders in the psychotic spectrum as well as the treatment of other mental health problems co-morbid with these disorders Clinical Psychologists are called upon to provide workshops and seminars in these areas (1998, Work Value Document, Western Australia Clinical Psychology Health Sector, p.19).

ACPA is deeply concerned about the lack of regard for accredited post-graduate clinical training within the profession by those who have not undertaken such training, and those who represent the majority of psychologists without this training. We are concerned that any attempt to reduce the distinction between those with accredited post-graduate training in clinical psychology and those without this training will act to remove incentives for such training, further undermine standards, and lead to an exodus from the profession of the best trained clinical psychologists. Importantly, such a result would subject the public to a lack of trained and qualified clinical psychologists in the future, thereby increasing risk to the public. The mentally ill are amongst our most vulnerable members of society and require a high level of expertise in their management.

Recommendation:

We strongly recommend the retention of the two-tiered Medicare rebate system in order to recognise the higher level of training in mental health undertaken by qualified clinical psychologists.

I humbly present my professional argument and opinion (together with those of ACPA) on this important matter affecting the mental health needs and fair access to evidence-based psychological treatment of the Australian public to the Senate Inquiry: Community Affairs Reference Committee.

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