1st August, 2011

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

Re: Proposed Cuts to Psychological Sessions under the Better Access Initiative

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My name is Dr Angela Green and I am a registered Clinical Psychologist with over 10 years clinical experience. I completed a Doctorate in Clinical Psychology at The University of Queensland resulting in a research publication. I am a Member of the Australian Psychological Society (APS), a Member of the APS College of Clinical Psychologists, and a Member of the Australian Association of Cognitive Behaviour Therapy (AACBT). I currently work as a private practitioner, which utilises my prior experience in community adult mental health, consultation-liaison psychiatry (public hospital-based), drug and alcohol (public hospital-based), Centrelink and the job-network, and tutoring of Medical students at The University of Queensland. I am an approved Supervisor with the Psychology Board of Australia (PBA) and provide supervision to post-graduate Clinical Psychology students, as well as registered psychologists seeking membership of the APS College of Clinical Psychologists.

Summary
This submission to the Inquiry being conducted by The Community Affairs Committee of the Australian Senate pertains specifically to Term of Reference point (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 Medicare*.

In particular, this submission seeks to highlight that any reduction to the number of treatment services for Psychologists will: 1). adversely impact upon the specific and varied needs of Australians with mental health disorders; 2). create a false economy; 3). ignore empirical evidence for the recommended treatment of high-prevalence disorders with varied complexities and severities; and 4). increase future Government expenditure. Alternatives to the proposed cutting of the number of psychological sessions under the *'Better Access Initiative'* are also suggested.

Dear Committee Secretary,

In a Federal Budget cost-saving measure – ironically to fund the Government's new commitment to mental health – from 1st November, 2011, the yearly maximum allowance of sessions of psychological treatment under the *'Better Access to Mental Health Care Initiative'* (*'Better Access Initiative'*) available to a person with a recognised mental health disorder will be reduced from 18 to 10, with no 'exceptional circumstances' enabling additional sessions. The slashing of

eight sessions will effectively restrict access to psychological treatment contradicting the objective of better access!

In the beginning…

In 2006, the Council of Australian Governments (COAG) released a National Action Plan on Mental Health (2006-2011) (14 July, 2006, p.3), which stated that *"people with mental illness often require access to a range of human services provided by Commonwealth, State and Territory governments and the private and non-government sector. Better coordination of all these services can help to prevent people who are experiencing acute mental illness from slipping through the care 'net' and reduce their chances of readmission to hospital, homelessness, incarceration, or suicide. Better coordinated services will also mean that people can better manage their own recovery".*

As highlighted by COAG *"an effective care system will provide timely and high-quality health and community services to people with a mental illness that assists them to live, work, and participate in the community. An effective, integrated care system has several parts working well together, which can include psychiatrists in the community and a primary health care sector of GPs,* ***psychologists****, mental health nurses, and other allied health workers that provide clinical services to people with* ***mild, moderate and severe mental illness****, including early identification, assessment, continuous care and case management".*

Complexities and Severities

COAG identified in the National Action Plan that the *'Better Access to Mental Health Care Initiative'* would serve to enhance the provision of care to individuals with recognised mental health illness of mild, moderate, and severe natures. This was a timely initiative that offered an alternative to medication-only or no treatment options for Australians who had been unable to afford self-funded psychological interventions.

Over 2 million Australians to date have accessed psychological treatment under the *'Better Access Initiative'* – 83% of whom were rated by their referring medical practitioner to have high to very high symptomatology prior to psychological treatment. A recent audit survey conducted by the Australian Psychological Society (APS) collated the data of 9,900 *'Better Access Initiative'* consumers. It found that **80.8%** of consumers who required more than 10 sessions of treatment had a high-prevalence disorder including, depression and/or anxiety disorders. On referral, **83.6%** were rated by the treating psychologist as having a moderate-to-severe (40.5%) or severe presentation (43.1%) whilst only 0.2% were rated as having a mild presentation. Furthermore, the survey found that **42.5%** of consumers had complex presentations with comorbidity (i.e., another mental disorder, drug &/or alcohol abuse, or a personality disorder).

Despite this overwhelming evidence, the Federal Government's rationale for the proposed cut to psychological sessions is that *"the new arrangements will ensure that the Better Access Initiative 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 with more appropriate treatment through programs such as the Government's Access to Allied Psychological Services program".* Mild or moderate severity! Frankly, this is inaccurate and highly offensive to those individuals who have astutely and courageously sought treatment of

their psychological condition/s under the *'Better Access Initiative'* to improve their psychological, occupational, relationship, and social functioning, and overall quality of life.

In the first three years of the *'Better Access Initiative'* (2007–2009), 2,016,495 unique consumers received services from psychologists under the Initiative and 262,144 (13%) of these consumers received more than 10 sessions of psychological treatment. The Federal Government has argued therefore, that only 13% of consumers treated by psychologists will be affected by the proposed cut in sessions. Firstly, a more rigorous evaluation of the reason/s why 87% of consumers attended less than 10 sessions will most likely reveal factors extraneous to the achievement of desired treatment outcomes (e.g., comorbid substance abuse, inability to pay treatment gaps, severity of mental illness). Secondly, if such a small percentage of consumers (13%) utilised more than 10 sessions, then this would represent not only a small percentage of the expenditure, but the greatest of impact to a cohort most affected by mental health disorder/s.

Cost-(In)effectiveness

In 2011, the Federal Government's own *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative (2011)* found that the *'Better Access Initiative'* provided benefit to consumers and was a cost-effective way of delivering mental health care. More specifically, *"Better Access care provided by psychologists would appear to represent good value for money for Government"* (p. 40). The typical cost of a package of care delivered by a psychologist under the *'Better Access Initiative'* was $753.00 – significantly less than ATAPS, which is estimated to cost 2-10 times more per session than the Initiative.

The ATAPS program run through the Divisions of General Practice (DGPs) is not a viable referral option under current arrangements. Even despite the Federal Government doubling the ATAPS funding, there is simply not enough to provide services for the estimated 260,000 number of consumers (or 86,000 per annum). Furthermore, 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 whilst more experienced psychologists cannot viably undertake the work.

The Federal Government has also proposed that if individuals require more than 10 sessions of psychological treatment, they can be referred to a consultant psychiatrist. This recommendation is not realistic as there is a significant shortage of psychiatrists; the majority have lengthy waiting lists; most do not offer or specialise in the application of therapy; and have a prohibitive gap fee in the range of $200 per session.

Successful psychological treatment reduces costs of hospital admissions and allows many consumers to return to work, with the associated productivity benefits. With access restricted to psychologists, it would seem likely that there will be an increase in consumer presentation to GP's and hospitals – and with that an inevitable increase in economic cost. Therefore, with little to be gained and much to be lost, proposals to slash the number of psychological sessions under the *'Better Access Initiative'* are not indicated and should be rejected.

One size does NOT fit all

Doubling the funding for the ATAPS program will not benefit the majority of consumers who have accessed psychological treatment under the *'Better Access Initiative'*. The majority do not need to participate in treatment involving multiple disciplines (i.e., psychiatry, social work, occupational therapy, mental health nursing) in order to access psychological treatment. Consumers are already able to successfully access psychological treatment and achieve effective gains without the utilisation of team-based care. However, the proposed cut in sessions to the *'Better Access Initiative'* would limit access to effective psychological treatment. Additionally, the vast majority of these consumers would also be denied access to public sector mental health services (i.e., ATAPS) as they have high-prevalence disorders and are not necessarily in need of team-based care. It is apparent, therefore, that the proposed changes to the *'Better Access Initiative'* reflects the Federal Government's true lack of understanding of the specific and varied needs of Australians with mental health disorders.

Evidenced-Based Treatment

Another significant lack of judgment on behalf of the Federal Government is the assumption that the same treatment outcomes can be achieved with essentially half the amount of sessions (reduced from 18 to 10 per annum). This is unrealistic and inconsistent with scientifically-researched, empirical evidence that recommends 15-20 sessions of psychotherapy for the treatment of high-prevalence mental health disorders. For example:

1). The National Institute of Clinical Excellence (NICE, UK; 2005) established National Clinical Practice Guidelines, which recommended the following amount of treatment sessions specific to each mental health disorder:

- Posttraumatic Stress Disorder – *Simple* (Guideline 26, pp.63-64) = 8-12 sessions
- Generalised Anxiety Disorder (Guideline 113, p.17) = 12-15 sessions
- Panic Disorder (Guideline 113, p.29) = 7-14 sessions
- Major Depressive Disorder (Guideline 23, pp.28-29) = 16-20 sessions

2). In 2009, the Australian Centre for Posttraumatic Mental Health and Rural Health released Guidelines for the treatment of a *Simple* PSTD, which recommended 8-12 sessions. A more complex PTSD presentation (i.e., several problems arising from multiple traumatic events, traumatic bereavement, or where PTSD is chronic and associated with significant disability and comorbidity) recommended further sessions using specific treatments to address the problems.

3). In 2010, the Australian Psychological Society (APS) conducted a literature review, which recommended the following amount of treatment sessions specific to each mental health disorder:

- Generalised Anxiety Disorder = 14-30 sessions
- Panic Disorder = 7-18 sessions
- Obsessive-Compulsive Disorder = 12-17 sessions
- Major Depressive Disorder = 16-20 sessions
- Drug and/or Alcohol Disorders = 52 sessions
- Posttraumatic Stress Disorder – *Simple* = 8-16 sessions
- Hypochondriasis = 9-16 sessions
- Adjustment Disorder = 7-14 sessions

The proposed Federal Budget changes to the *'Better Access Initiative'* ignores scientific evidence, ignores clinical recommendations, and therefore ignores the diverse needs of Australians with mental health disorders. Rather than taking an overly simplistic approach to determining the needs of consumers (i.e., relying on a median number of sessions), treatment needs including, the number of treatment sessions, should be empirically determined and aligned with clinical recommendations relating to demonstrated treatment outcomes. It is not appropriate to simply qualify mental health as 'severe' or 'less severe'.

Burden of Disease

"Recognition of the extent to which mental illness contributes to overall ill health and its economic implications have increased substantially in recent years. Although mental disorders account for only 1% of deaths, they are responsible for an estimated 11% of disease burden worldwide" (The World Health Organisation: WHO).

"The WHO projected that this will rise to 15% by the year 2020. Within Australia, the Australian Institute of Health and Welfare reported that mental illnesses are the largest single cause of disability in Australia, accounting for 24% of the burden of non-fatal disease (measured by total years of life lived with disability)".

Given the high and increasing burden of disease associated with mental illness in Australia, the cutting of any established mental health initiatives or programs that have demonstrated cost-effectiveness in the treatment of recognised disorders, is nonsensical, represents poor return on investment, and lends itself to a false economy (i.e., cutting funding which may initially save money but, over a longer period of time, will result in more money being wasted than saved).

Alternatives to the proposed cut in sessions

It is understood that the Department of Health and Ageing has had to follow a Government imperative to demonstrate cost savings and that this is non-negotiable. However, it is abundantly clear that there is an obvious and significant gap in mental health service provision for those in the community presenting with a range of recognised mental health disorders that vary in complexity and severity.

There are assorted arguments for and against the maintenance of the 12-18 sessions under the *'Better Access to Mental Health Care Initiative'*. Some of these are politically-driven, some are economically-driven (although a false economy may be more indicated), but unfortunately few are clinically-driven. As alternatives to cutting the number of psychological sessions under the *'Better Access Initiative'*, it is proposed that the following instead be considered:

→ Firstly, a methodologically-rigorous evaluation of the current *'Better Access Initiative'* be conducted to more accurately identify the number of psychological sessions required to achieve desired outcomes. This would go beyond reporting the median number of treatment sessions delivered by self-selected psychologists (as was done in the *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioner through the Medicare Benefits Schedule Initiative, 2011)* and instead, would incorporate a range of complexities and severities associated with the diagnosis and treatment of recognised mental health disorders. Factors that would ideally be taken into account in a more rigorous evaluation should include, (a) the employ of an

independent evaluator, (b) the utilisation of a range of validated outcomes measures that are relevant to the disorder being treated to assess treatment efficacy (the Government's evaluation relied primarily on the reliance on the K-10), (c) the investigation of reasons for which consumers discontinued treatment (i.e., attending less than 10 sessions does not necessarily mean that treatment outcomes were achieved; and (d) evaluation of short-, medium-, and long-term treatment outcomes.

→ Secondly, that empirical recommendations already documented in Australian and International Guidelines (as aforementioned) also be utilised for the determination of the number of psychological sessions required to achieve desired treatment outcomes.

→ Thirdly, that future Government expenditure be streamlined based on treatment provider type (e.g., Clinical Psychologist comparable to a Generalist Psychologist). Clinical psychology is the only mental health discipline, apart from psychiatry, whose ENTIRE accredited training is specifically focused in the field of evidence-based assessment, case formulation, diagnosis, and evaluated treatment of the full spectrum of lifespan mental health disorders across the full spectrum of complexity and severity of the mental health disorders. The proposed cuts to rebated session numbers directly speaks to the work of Clinical Psychologists and to the most complex and severe mental health presentations for which they are uniquely trained to treat.

Whilst new investments in mental health care are important and are to be applauded, they should not be at the detriment of established programs that have been found by the Governments' own evaluation to be working effectively. Therefore, proposals to slash *en masse* the number of psychological sessions are not indicated and should be rejected. Committee Secretary, I urge you to instead recommend the maintenance (at the very least) of the current amount of psychological treatment sessions under the '*Better Access Initiative'* to be 12, with an additional 6 sessions for 'exceptional circumstances'.

Thank you for reading this submission. I trust that it will be given due consideration.

Sincerely yours,

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Clinical Psychologist