Commonwealth Funding and Administration of Mental Health Services

Senate Inquiry: Community Affairs References Committee

Submission by: Christopher Semmens, Clinical Psychologist,

I welcome the opportunity to make comment on some of the terms of reference of this Senate Inquiry. I have restricted my comments to aspects of the following terms of reference:

(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 was announced in the 2011-2012 Budget that a change would be made to the number of allied mental health treatment services for patients with mild or moderate mental illness under the Medicare Benefits Schedule (MBS) Better Access Initiative from a maximum of 18 sessions to a maximum of 10 sessions in a calendar year. The Better Access Initiative recognises a two tiered categorisation of the services offered by psychologists: (i) Psychological therapy provided by eligible clinical psychologists (PTCP), and (ii) focussed psychological strategies provided by eligible registered psychologists (FPSP).

The change in the number of treatment services has been made, it would seem, with no consideration having been given to the significant distinctions between these two tiers as they apply in a number of important matters relating to the delivery of services to those with mental illness.

Clinical psychologists have accredited post-graduate qualifications in the specialty of clinical psychology and accordingly have advanced training in the assessment, diagnosis, case formulation, treatment planning, clinical decision making, psychotherapy, and outcome evaluation of mental health disturbances.

If we consider the issue of describing mental illness as “mild”, “moderate” and “severe” then there is the question of what it is that characterises an illness as falling under each of these descriptors. One possible way of distinguishing between these descriptors might relate to the number of sessions of what kind of therapy would be required to assist the person to a resolution of the disturbance or to the achievement of a lessening the interference that the condition has on one’s

life. If schizophrenia, other forms of psychosis, and bipolar disorders (amongst others) are seen as illnesses in the "severe" range, then the "moderate" range has necessarily got to have very wide inclusiveness. Under the "mild" category would be conditions that would require not many sessions short of the new 10 session limit.

Along these lines the Budget decision to reduce available sessions to 10 could effectively be seen to restrict an extraordinarily well trained workforce with specialised clinical psychology skills – continually refined by (required) ongoing professional development training - to treating essentially "mild" cases while the "moderate" cases – who actually most require the application of the specialised skills that the clinical psychologist brings to the table – will either continue to miss out (as so many of them did prior to 1 November 2006) or be corralled into accessing services that are less efficiently targeted to their disturbances than would be those provided by private clinical psychologists.

For example, while psychiatrists are arguably the most appropriate principal service deliverers for schizophrenia, the other psychoses and bipolar illnesses amongst others (severe mental illnesses), specialist clinical psychologists, in the main, are the most appropriate principal service deliverers for traumatic stress (including but not restricted to PTSD), personality disorders and anxiety disorders amongst others (moderate mental illnesses).

Public clinics usually have long waiting lists (3 to 6 months is not uncommon) and accordingly tend to be selective of the more chronic and severe consumers. ATAPS services are much less likely to be populated by the kinds of experienced specialist clinical psychologists who are more likely to be available as private practitioners. Furthermore, the practical realities of the operation of the ATAPS services, are that, while some of these programmes will benefit from the involvement of a clinical psychologist with accredited specialised post graduate training in mental health, there is no requirement for this advanced training to have been achieved by those professionals involved in the programme, and those professionals are restricted to utilising short term strategies. This situation exists despite the Budget increasing Tier 3 ("severe and persistent" mental illness) funding for ATAPS.

While the I am opposed to the reduction of sessions available under the Better Access Initiative in general, I am particularly concerned about the reduction of sessions applying to the provision of psychological therapy by clinical psychologists (PTCP). It is seen to be more likely that the 10 session limit will be workable for the provision of focused psychological strategies than for the provision of psychological therapy.

This is one of the key limitations (amongst many) of bracketing (i) psychological therapy delivered by clinical psychologists (PTCP) on the one hand and (ii) focussed psychological strategies delivered

by registered psychologists (FPSP) on the other together in the way that has been done in the Better Access Initiative, and particularly in regard to the Budget changes.

Clinical psychologists with their advanced post-graduate specialised training in mental health are well placed to make reliable decisions about the best treatment approach to apply in certain circumstances as well as the number of sessions that may be required to fulfil a course of treatment. The Budget changes impose significant restrictions on the clinical psychologist to, in many cases, apply this specialised training. I am of the view that Australian society would be very much better served if clinical psychology services were actually extended beyond the current limit of 18 sessions to 20 or 25 sessions.

If a particular case (say uncomplicated panic disorder) is seen by a clinical psychologist to only require say 6 sessions (though the textbooks would say 12), that would not change if the maximum number of sessions were kept at 18 or even extended to 20. But if a difficult case of say depression co-morbid with borderline personality disorder and childhood physical and emotional abuse from neglectful parenting – and there are plenty of cases like that seen not infrequently by our members - 10 sessions is rarely going to be enough to achieve what would be required to be covered in the clinical psychology sessions to significantly reduce the interference to that person's life by that combination of problems.

While drug therapy delivered by a psychiatrist may be appropriate as an adjunct therapy for the depression component of that constellation of problems, it is the specialist expertise of the clinical psychologist who is best suited to assisting with resolving the traumatic stress of the neglectful parenting, and the adjustment of the person in terms of their view of themselves and how they see themselves in relation to the world and the other people in it.

With only 10 sessions available there is likely to be work left undone in this case example that may mean that that person would remain dysfunctional, and that may have adverse effects on others around that person.

To argue that it would be inappropriate for such a case to be seen by a private clinical psychologist – because there are only 10 sessions available and this set of problems would require 18 to 20 sessions – is to very much underestimate the quality of the accredited post graduate training in specialist clinical psychology in Australia. Accordingly this workforce of extraordinarily well trained clinical psychologists would remain considerably underutilised while the consumers of this kind would be unlikely to be able to access better quality treatment through the public system or ATAPS.

Another significant drawback from bracketing PTCP with FPSP is that the training and expertise of clinical psychologists to undertake effective treatment planning and case management becomes obscured. A clearer distinction between the two would allow for the practical and parsimonious

proposition that instead of the need for GPs to have to go to the trouble and expense to Medicare of preparing Mental Health Plans (MHPs) for clinical psychologists, GPs could simply refer appropriate clients to clinical psychologists in the usual way of referring to most other specialists thereby leaving it to the clinical psychologist to do the treatment planning and implementation.

This would result in significant savings to Medicare - including those cases where MHPs are drawn up and paid for by Medicare and the client does not then go on to access allied health service provision. These savings would go a long way to offsetting any net additional expense that may arise by lifting the maximum number of sessions for PTCP to 20 keeping in mind that probably most cases will not require the full 20 sessions.

Recommendations:

1. I recommend that issues related to psychological therapy provided by eligible clinical psychologists (PTCP) be considered separately to those relating to the provision of focussed psychological strategies by registered psychologists (FPSP).
2. That the maximum number of sessions available for PTCP be increased to 25.
3. For referrals from GPs to clinical psychologists the need for the preparation of a Mental Health Plan be discontinued.

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

See above.

(d) services available for people with severe mental illness and the coordination of those services

See above.