Submission to the
Commonwealth Funding and Administration of Mental Health Services
Senate Inquiry: Community Affairs References Committee

Thank you for the opportunity to make this submission.

I am a Specialist Clinical Psychologist and a foundation member of the Australian College of Specialist Psychologists. I have over 40 years experience in the field of mental health.

For the past eight years I have been working in the inland Wheatbelt region of Western Australia from two rural based private consulting practices. Rural patients often present with a complex of psychological, physiological, social, and chronic disease factors to an extent and chronicity I had not experienced in my former city based practice. For this reason, I wish to outline to the Committee the realities of service delivery in a rural setting, and how what is being achieved could be vastly assisted through a revision of current government practices and infrastructure.

I also wish to register my very deep concern regarding the Better Access initiatives that would reduce, rather than increase, the number of consultations available to patients; and the assumption that clinical psychologists only treat patients with low to moderate mental health illnesses. This assumption is so totally ill informed that it raises very real concerns about the efficacy of the advice being received by the government.

The bulk of my patients have chronic moderate to severe mental illness (psychological disorder). Often these patients also have chronic and severe presentations that include co-morbid physical illnesses. Due to the complexity of these presentations, services have to be provided by a clinical psychologist who has advanced knowledge of assessment, diagnosis, case formulation and treatment modalities.

Most of the patients I have seen have never had previous access to psychological treatments that work. Many have had non-specific counselling, been prescribed psychotropic drugs, or admitted to psychiatric hospitals. At best these treatments represent a band-aid approach to contain immediate problems.

The provision of psychological treatment by a clinically trained psychologist in conjunction with a rural medical centre makes services accessible and highly effective, thus achieving long-term reductions on a range of medical and hospital services. For example, my work involves liaison at the local level with medical practitioners, the practice nurse, and Personal Helpers and Mentors (PHaMs). All are provided with information about the patient to ensure continuity of care. Personnel from PHaMs who provide practical help on the ground get regular care briefings from myself and, where useful or feasible, they can sit in on consultations.

However, access to clinical psychology services in a rural location can present special challenges for many patients. The following is a typical example.

A farmer with suicidal intentions is brought to a rural medical centre. The doctor immediately contacts me and I make time for an urgent consultation. However the current Medicare system throws up barriers:

a) The general practitioner may prescribe medication but not have the time to undertake the paperwork required for a Mental Health Care Plan – thus technically, the patient cannot access a Medicare rebate which they may depend upon.

b) The patient may need to be seen for an extended session over 50 minutes however there is no Medicare item number to accommodate a 50 to 90 minute consultation. Such extended sessions are not unusual with the clinical psychologist bearing the additional time cost.

c) The spouse/family member/partner may need to be seen to review risk factors, yet there is no provision for this in the current Better Access arrangements.

The inflexibility of current Better Access arrangements becomes evident when, for example:

- Each member of a family of say four people who have experienced trauma (motor vehicle accident) may have to be screened for further psychological intervention.

- A bushfire victim may seek one or two follow-up consultations after 12 months have elapsed.

- A patient with a previously treated anxiety disorder who has had 12 sessions may need to return in the face of an unexpected crisis and partial relapse.

In all these cases the individuals involved who have psychological issues have to re-attend their medical practitioner for the necessary paperwork so they can be eligible for Medicare benefits.

Recommendations

a) Change Medicare referral processes to allow for flexibility in ensuring rapid access to specialist services in psychology.

b) Add more Medicare items for specialist clinical psychologists to provide for shorter and longer consultations.

c) Increase the number of sessions available for clinical psychologists to at least 20 to reflect current research and findings from clinical practice (see below).

d) Add a Medicare item to provide for other family members to be seen in joint or separate sessions.

The need for specialist clinical psychologists

The advantage in having a clinical psychologist is that specialist practitioners have the capacity to rework procedures to meet the unique nature of differing clinical situations. Psychological intervention must begin and end with the condition of the patient and not be straight jacketed by a Medicare template designed to fit all circumstances. Whatever the degree of mental illness (mild, moderate, 'advanced') one of the primary tasks is to help the patient engage with life while dealing with the effects of psychological disorder (mental illness).

A more holistic and systems oriented approach can lead to major initiatives that assist the patient to move forward. For example, there are often other potent avenues to recovery (such as job, housing, relationships and personal mentoring, etc) as well as symptom reduction and clinical stability. Overview by a specialist in psychology can often assess the most appropriate pathway forward.

Clinical psychologists are at the forefront of intervention research and clinical practice to expand models of service delivery. My own clinical work and on-going research is

concerned with how to make decisions about the sequencing of interventions for the individual patient, and in so doing to build multidisciplinary collaboration.

The vast majority of my patients are bulk billed to ensure equality of access to psychological treatment. In this way I am working within the ethos of making services accessible to those who would find such access unavailable. As a result I am essentially running a rural outpatient clinic as part of my consulting practice. This results in a half-day or more of follow-up administrative work plus expenses. This includes treatment planning and provision of treatment resources to patients, liaison with medical practitioners and others, correspondence, referral of patients to facilities such as inpatient detox services, Court and Centrelink reports, sending requests for medical records, email treatment support, calls from patients out of hours, hospital visits and travelling expenses which can be considerable. None of this is subject to any form of reimbursement or remuneration.

Recommendation
Develop innovation in service delivery by funding specialist clinical psychologists to build new service delivery paradigms within small rural and remote medical clinics or medical/community health centres.

To undertake this work it is mandatory to have specialised postgraduate training and endorsement plus considerable clinical experience and up to date research-based knowledge so that psychological treatment strategies can be optimized. So that a local and rural based clinical service like mine can be retained and the overheads absorbed it is essential to maintain the upper tier of Medicare rebates available to specialist clinical psychologists.

Recommendation
That the Committee consider increasing the rebates to specialist psychologists to encourage, retain, and attract delivery of comprehensive services in rural locations.

<u>Reduction in the number of consultations.</u>
In the context of my clinical practice I was surprised and dismayed to see in the Federal Budget announcement that the number of sessions for members of the public to access specialist Clinical Psychologists under the Better Access Scheme was being cut from 12 to 18 sessions, back to 6 to 10 sessions.

My patients with moderate to severe mental illness average about four or five out of every ten and require the current 12 to 18 sessions currently available under Medicare. While new generation psychological treatments can be very effective within the first ten sessions, for many patients there needs to be al least 20 sessions available. This is because recovery may take time, as does a shift to a persistent pattern of adjustment and adaptation. The individual's environment can change, including people, and brief psychological interventions need to be available when and as required.

Recommendation
It is recommended to the Committee that the number of sessions available to specialist Clinical Psychologists be increased to at least 20 to reflect clinical realities and the findings of current research.

Access by mental illness sufferers to specialist Clinical Psychology treatment has been significantly downgraded while only last year the government boasted that it had increased access to services.[i]

It is disingenuous and, I can only describe it as political spin, to argue 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 (emphasis mine) *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 (ATAPS) program'*.[ii]
The above statement from the Budget papers is bizarre as the dichotomy between mild or moderate and 'advanced' mental illness makes no logic in clinical practice. **A specialist Clinical Psychologist with advanced training is in the best position to determine the status of the person in these terms, even if such a determination were desirable or appropriate.**

Many of my patients with moderate to severe mental illness ('advanced') **are in fact referred to me** by the Divisions of General Practice and State mental health services because they do not have the resources or clinical expertise available, or funded, to provide specialized psychological treatment services. In addition, if patients were to access such services they would in all likelihood be exposed to practitioners who do not have dedicated post-graduate training in mental health and/or any significant psychological training. In addition, they would have considerable travelling expenses, which most simply cannot accommodate in their budgets.

The government's budget proposal to wind back access to specialized Clinical Psychology services appears to be based on a false premise that patients seen in private practice have mental health problems which are **'mild to moderate'** in severity and are not those most in need.

As a practicing specialist Clinical Psychologist I would like to indicate as highlighted above that the patients seen in the Better Access Scheme by specialists, have complex and serious mental health issues, covering problems such as co-morbid personality disorders and addiction, self harm and suicide issues, trauma syndromes, depression which is very incapacitating, severe anxiety which greatly effects work performance and ability to function, or children who live in dysfunctional families and/or have severe problems within the school system. All this has massive cost and productivity implications. These are the **TYPICAL** type of patients seen by private Clinical Psychologists.

To suggest that specialist psychologists can professionally work within a 6-session framework to provide proper assessment and therapy intervention is demeaning to our patients and has ethical implications. What will our patients do when the 6 or 10 sessions run out and they have not fully improved or recovered from their mental health problems? Specialists providing psychological treatment cannot work effectively under such constraints and no medical specialist would be expected to do so.

As noted above my practice is based in rural Western Australia and covers a vast catchment area. A large percentage of patients have complex co-morbid conditions that have gone untreated for years and sometimes decades. These patients have no other options in getting comprehensive psychological treatment if their eligibility for Medicare runs out. The Royal Australian and New Zealand College of Psychiatrists was recently quoted as saying that almost two thirds of people with mental illness do not receive any treatment in a twelve-month period.[iii] (It could be postulated that rural areas exceed this figure given the scarcity of mental health services and barriers to accessing what is available such as travelling costs). By cutting back on treatment sessions the Government is rationing care to those who need it most and putting lives at risk. The Government needs to be targeting recovery rather than inflexibly limiting services across-the-board on the grounds of efficiency or dubious cost savings. It represents micro policy making without awareness of the ramifications.

The suggestion that specialist Clinical Psychologists typically see patients with 'mild to moderate' psychological disorders is not supported in the reviews of the Better Access initiative or the Australian Psychological Society's research. The latter research found over 80 per cent of patients were reported as presenting with moderate to severe levels of symptom severity.

The suggestion that sufferers with 'advanced mental illness' (whatever that is) will be '…provided more appropriate treatment through programs such as the Government's ATAPS program is hyperbole and dangerously misleading. The ATAPS program must have undertaken a behind the scenes metamorphosis as in the *Budget Statements – Department of Health and Ageing*, it is stated that the ATAPS program was being expanded to target hard to reach areas and communities that are currently underserviced, such as children, indigenous communities and socio-economically disadvantaged communities (see pages 312-313). The February 2010 review of the ATAPS program the Department of Health and Ageing emphasized that '*ATAPS funds the provision of* ***short term*** (emphasis mine) *psychology services for people with mental disorders…*'[iv]

In order to rationalize significantly reducing access to specialized psychological treatment the Government is talking up ATAPS, but this appears to be a smokescreen for it's cut and paste approach to funding. The bureaucratized and medically dominated Divisions of General Practice simply do not have the capacity to deliver the psychotherapeutic and holistic rehabilitation interventions that people with severe mental illness require plus there is always the stigma of medicalizing the individual's problems. When combined with the inadequately run and resourced state-based services the picture for the mentally ill and their access to specialized Clinical Psychology services and psychological treatment is indeed bleak (the development of public community mental health was ignored in this budget).[v]

It is ridiculous to have two signposts as suggested by the Government in the budget, with mild and moderate mental illness sufferers going in one direction, and those with 'advanced' mental illness going in another. This is grossly misinformed policy making and also represents a narrow focus on symptoms and pathology and oversimplifies the complexity of mental illness and the context in which it occurs.

The ATAPS program was not designed to replace or to compete with the Better Access initiative.

There must be flexibility in delivery of services so that those particular patients who require further treatment sessions or follow-up assistance can get help. I would like to highlight the following points:

- Even with successful psychological intervention, reflected in such things as re-engagement with the community and an enhanced quality of life, the principle of 'nonlinearity of course' is ever present. This means that people with mental illness can experience a fluctuating course of illness that interacts both with the environment and with the individual's efforts.

- A premature cut-off of the patient's treatment can severely compromise therapeutic outcomes and undermine long-term personal recovery.

- It is advantageous for the person to have access to someone they know and trust. It is

very common to hear from mental illness sufferers that they have been shunted from pillar to post with their subjective life experiences that impact on their mental health either not understood or explored. Mental health recovery is an intensely personal process and it can be held back by the inflexibility of unduly limiting Medicare funded treatment to those in need.

- The patient with a history of mental illness may need to attend briefly in order to learn how to solve or bypass new problems that are unrelated to their illness but could exacerbate their condition. We need to focus on assisting individuals to manage their own conditions while pursuing a meaningful life and not have individuals resort to medication or self-harm in a crisis because of inflexible service provision. In my experience if specialist Clinical Psychology consultations were to lapse the patient can end up being hospitalized for days, all booked on Medicare.

Research should guide policy making on the number of sessions required for both treatment and recovery from mental illness. The number of Medicare funded sessions available prior to the budget are themselves grossly inadequate:

- An Australian study found that 'The current (Government) policy appears to be suitable for only about one-third of clients who carry the burden of psychological illness'.[vi] The findings of the study, which are roughly consistent with those found elsewhere, suggest that a minimum benefit should be closer to 20 sessions.

- Another study conducted by the National Institute of Mental Health found that 16 weeks of specific forms of treatment is insufficient for most patients to achieve full recovery and lasting remission.

- In the Federal Government Better Access review there were no recommendations saying that the number of sessions to Clinical Psychologists should be cut.

- The Australian Psychological Society Better Access Review suggested that around half of people would require more than 10 sessions of therapy.

Policy needs to promote radical reform, or transformation, of the mental health system so that it is responsive to the needs of individuals and their families across all age groups in the body, space and world of the individual. The president of the AMA Dr Andrew Pesce was quoted on the ABC news web site on 11 May 2011 saying essentially that the government needs to understand and appreciate the role of the general practitioner in treating mental health and this is also the case with specialist clinical psychology.

Richard Taylor
Specialist Clinical Psychologist

Foundation member *Australian College of Specialist Psychologists*
28 July 2011

---

[i] Outcomes and proposed next steps: Review of the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program, February 2010.

[ii] Gcvv Sections taken from the Federal Budget 2001 (sic) under the heading 'National Mental Health Reform – Better Access Initiative – rationalisation of allied health treatment sessions.

[iii] Quoted by Michael Vincent in, Doctors attack mental health 'penny pinching'. ABC News, 11 May 2011.

[iv] Ibid.

[v] See A. Rosen The news on mental health: encouraging, worrying, disappointing, and promising. Croakey health blog, 11 May, 2011.

[vi] P. Harnett, O'Donovan A., and Lambert, M.J. (2010) 'The dose response relationship in psychotherapy: Implications for social policy'. *Clinical Psychologist*, 14 (2) July pp. 39-44.