

August 5<sup>th</sup>, 2011

***Submission regarding the Commonwealth Funding and Administration of Mental Health Services***

Thank you for the opportunity to submit my viewpoint on the funding and administration of mental health services in Australia. I am writing particularly in response to the proposed changes to the Better Access to Psychologists, OTs and Social Workers initiative.

My name is Krystyna Kidson. I completed my Masters of Psychology (Clinical) from the University of New South Wales in 2005. I had immediate employment, continuing work I had began in my final placement in developmental and clinical treatment trials for behavioural problems in children. As a result of this work, I was head-hunted for private practice in the Hornsby area, and subsequently also joined a private practice in the Sutherland area in 2006. Currently, I am on an indefinite period of maternity/family/study leave, and have a non-practicing registration with AHPRA, but hope to return to the profession in several years. I was a clinical psychologist, but chose not to pursue that recognition with Medicare and the Australian Psychological Society because, should I hold such recognition at my practice, my clients would have had to pay \$150 per session to see me, and I am not comfortable asking people to pay so much per session. I frequently charged concession rates of approximately \$90-100 per session when clients had a need and a Mental Health Care Plan from their GP, and bulk-billed on request by the client's GP.

I am seriously concerned with the threatened cuts to the number of sessions available under the Better Access Initiative, as both a practitioner-on-leave and loving friend and family member.

Contrary to many published comments by government representatives, the current system established at the inception of Better Access in 2006 allows a client to access rebates for 12 sessions per calendar year, with an option for a further six sessions under "exceptional circumstances". These exceptional circumstances are defined in the Medicare Benefits Scheme as "a significant change in the patient's clinical condition or care circumstances which make it appropriate and necessary to increase the maximum number of services". In practice, these "care circumstances" are often the need to consolidate the clients' gains to minimize risk of relapse, or to treat more entrenched conditions or cognitions.

However, the Government has recently decided to change this to rebates for six sessions per calendar year, with the option for a further four sessions for additional treatment, and no allowance for "exceptional circumstances".

The plan to cap psychological intervention at 6 (+4) sessions per year, under any system, falls below standard treatment protocol for the management of even the most uncomplicated psychological conditions. In my own experience, literally only a handful of clients in my entire career have only needed six sessions, to deal with such issues as

bereavement, mild anger management problems, or *very* mild oppositional behaviour or anxiety in young children, which were causing them significant distress. Others have dropped out of treatment before or at the initial six session mark, typically due to factors such as financial or time constraints, low internal motivation to pursue the difficult course of therapy, and occasionally therapist-client mismatch due to age, gender or interpersonal style concerns. However, this group will need further treatment in the future to properly address the difficult cognitions and behaviours that sent them into my office in the first place.

Those of my clients who have completed treatment, have generally needed in excess of 10 sessions to address a variety of problems, from mild Opposition Defiant Disorder in children, to moderate and severe anxiety and mood disorders in adolescents and adults. They have needed these sessions to build rapport and trust in me, to then develop an understanding and acceptance about themselves and the factors that predispose and maintain their problems, develop the skills to manage these factors and concurrent negative thinking styles and behaviours, and then consolidate and practice those skills so well that the risk of relapse is minimised. It is difficult to imagine how all this can be achieved in 10 sessions, let alone six.

Indeed, recent research by the Australian Psychological Society (funded by the Department of Health and Ageing) shows that the average length of individual treatment for mental health disorders is 15-20 sessions. New research conducted by Harnett, O'Donovan and Lambert (2010) shows that for 85% of people to show clinically significant change in their level of symptom severity, around 20 sessions of treatment are required. ***This means that, around half the people who receive psychotherapy via Better Access will need more treatment if these cuts are allowed to occur.***

I would like to draw your attention to another recent study completed by the Australian Psychological Society, analysing 9900 clients who were seen in 2010 and required between ***10 and 18 sessions***. They found that 80% of these clients presented with moderate to severe presentations of depression or anxiety (or other high prevalence orders). At treatment completion, ONLY 2.5% of these clients still had severe presentation. ***This means that those extra 1-8 sessions make a significant difference in the wellbeing of these people.***

These 9900 represent the ***87000*** individuals who access between 10 and 18 sessions per year (an estimate based on the 262144 individuals who required 10-18 sessions under Better Access from 2007-2009).

However, if the proposed cuts to Better Access are carried out, these clients, and the ***thousands*** like them in the years to come, ***will not be allowed help*** beyond 10 sessions under Better Access, unless they pay for it themselves. Because the majority of them suffer mood or anxiety disorders without significantly life-threatening implications, they will at best have slow entry into public sector mental health services as they have more common disorders and are not necessarily in need of team-based care (eg community health access teams, formerly known as “crisis teams”).

It has been said that they can still see psychiatrists. But there aren't enough psychiatrists to

cover the need (thousands of extra patients per year who previously saw a psychologist), and anecdotally, many of these professionals charge a greater gap fee than psychologists, social workers or OTs do (eg. \$80 vs \$45 or \$25, as was the case in my practice), not to mention that many psychiatrists do not have the same grounding or affinity for effective behavioural “talking” therapies that these other practitioners do. Anecdotally, some psychiatrists do not like doing “talking therapies”, preferring instead to refer their patients to their other therapist to talk about their life issues. Yet, it is the way these clients think about their life issues that predisposes them to or maintains their disorder! Is it realistic to expect that psychiatrists can handle this extra load?

It has also been said that the ATAPS program will cover the severe presentations. But it does not have enough funding to provide services for anything like the 87,000 people per year who would require it, even assuming that the idiosyncratic rules governing its application in each district will allow every potential patient to access it. (I will let others, more knowledgeable in the running of ATAPS, to comment on this area.) Moreover, evidence has repeatedly shown that most people who have accessed the *Better Access* initiative already have moderate to severe mental health issues. I would also note that the degree of severity may not be evident at initial presentation (due to the nature of the disorder, client’s current circumstances, or client reticence in sharing such details until they’ve built trust and rapport in the practitioner!). I believe that splitting up mental health services in this way is baseless and will more likely just put another obstacle in the way of a client’s progress.

Limiting the maximum length of treatment at 10 sessions per year under Better Access is extremely unrealistic and will set those consumers up for failure. Many consumers will not reveal the more distressing or complex issues that are at the core of the problem for them (and thus require more treatment later on); or they will drop out of treatment, making them more prone to relapse or more severe disorders (with subsequent increased pressure on the health system and higher workplace costs); or they will pay for continued treatment out of their own pocket (which could be as much as \$1300 or more – imagine the impact of that on a single or low income family!) with associated financial and family stress; or they will have to prove the “seriousness” of their disorder to access further funding. The latter may have a number of detrimental consequences also, such as heightened vulnerability to stigmatisation, and if their therapist is not registered under the ATAPS system, they will need to start all over again with a new therapist (again placing increased pressure on the health care system and on themselves).

***Essentially, the more obstacles that a client experiences (whether external or internal), the more likely they are to drop out of therapy prematurely; again, making them vulnerable to relapse or more severe disorders; again, placing more resource and financial pressure on the health care system, and adversely affecting their families, friends and workplaces, increasing their potential to develop adjustment or other psychological difficulties.***

I do recognise that excellent progress is being made in recognising needs in the mental health system, and I congratulate the government on their foresight and assistance for these areas. However, new investment in mental health care should not come at the expense of our existing services that are already working well to improve the mental health of Australian citizens (e.g. since the inception of Better Access, treatment seeking rates for

depression have lifted from 35 to 46%! I'm afraid I cannot recall the source of this statistic, however). I fear that this new policy will be frustrating and inhibiting for many people, who will simply give up or avoid treatment altogether, and continue to suffer.

**On a personal note, I am deeply concerned about the impact such changes will have on my friends or former clients who are currently or recently recovered from serious mental health issues.** Without access to the full 18 sessions per year, more than one of them would not be here today. Yet, they would not have been rated of sufficient severity to quickly access these other initiatives proposed as replacement options for Better Access, and several would have completely refused to see a psychiatrist, based on previous poor experiences with psychiatrists (e.g. from overreliance on medication, poor rapport, poor communication or communication skills)! Another will not be able to afford treatment for her recently diagnosed post-traumatic stress (which, whilst the prognosis is excellent, still will need intense intervention for the next 18 months). Again, from what I understand of the proposed options available, her presentation would not warrant access to these other initiatives proposed as replacement options, whilst still placing incredible stress on her own and her family's functioning, and her marriage. Without Better Access, her treatment options and financial constraints would be extremely limited. (Even with Better Access, finances are still very tight).

I urge you to seriously consider the detrimental impact of these session cuts, and prevent them from being passed.

Thank you for your attention.

Yours faithfully,

Krystyna Kidson