To: Committee Secretary
Senate Standing Committees on Community Affairs
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CC: Minister for Mental Health
ministerbutler@health.gov.au

20 July 2011

Dear Sir/Madam,

RE: Senate Community Affairs Reference Committee inquiry into Commonwealth Funding and Administration of Mental Health Services

I draw your attention to the following *Terms of Reference* relating to proposed mental health reform,
currently under scrutiny as part of the Senate Community Affairs Reference Committee inquiry into Commonwealth Funding and Administration of Mental Health Services:
(b.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

The reduction in the maximum number of Medicare-rebated sessions is cause for serious concern. It will, in effect, impede access to the quality mental health care needed by people who are the most vulnerable, and impoverished members of our society.

This is because the reduction of rebated sessions does not take into account the *dose-response relationship* as it applies to psychology. The dose- response effect, repeatedly demonstrated by empirical research, has shown that the degree to which psychological services are effective is related to the number of sessions clients attend. Although some clients will not require more than a few sessions to significantly improve, many others require 12-14 sessions or more. Based on a review of my case-load over a number of years, these clients will present with **one or more** of the following:

- long-term depression
- eating disorders
- self-harming behaviours
- people with cancer, heart disease or other life-threatening illness who have a mental health diagnosis such as anxiety and or depression
- people with abuse histories
- substance mis-use or dependence
- social and economic disadvantage, such as in actual or impending homelessness, long-term unemployment and disability

In the review, people who need more than 10 Medicare-rebated sessions are described “those with serious mental illness,” and are required to access mental health services through the specialised public health system, private psychiatrists or ATAPS once they have accessed the 10 sessions. This proposal is fraught with potential problems. Thus the most disadvantaged are expected to *change therapists* – that is*, if they can access one*. I live in an area classified as “rural” and each of these services is difficult to access, due to factors such as ineligibility, long waiting periods, and for some, a “no new patients” policy. For others, the cost of private psychiatry is not an option because out-of-pocket expenses are unaffordable.

The requirement to change therapists further disadvantages these clients. The partnership shared between a client and their therapist, the *therapeutic relationship,* is fundamental to the effectiveness of psychological therapies, as shown by hundreds of outcome studies (Lambert & Barley, 2001).

Furthermore, the review proposes to redirect funding from Better Access into the ATAPS program, which it claims is more effective at meeting the needs of vulnerable and hard-to-reach groups. This proposal raises a number of questions, such as how will ATAPS meet the following stated aims as outlined in the review:

1. effectively treat the more severe and complex cases
2. increase efficiency
3. improve a team approach
4. engage hard-to-reach groups?

There are at least two serious flaws which make this unlikely. Firstly, the government has itself identified that the administration of ATAPS is costly, and those costs are increasing – up to 25% of its total budget, higher than the projected cost of 15% - as outlined in the 2010 Dept of Health and Ageing Review of the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program http://www.health.gov.au/internet/main/publishing.nsf/content/8573A6A3FAB3595BCA257700000D8E78/$File/review.pdf **In other words, at least 25% of the available funding has not found its way to direct patient care.**

By contrast, Better Access directly funds patient rebates. Psychologists liaise directly with GPs or psychiatrists, and although the Review has noted that communication between the medical practitioner and the psychologist could be improved, checks are in place requiring a minimum of three written communications between these parties. To be specific, the audit process has ensured that Medicare rebates do not apply if the psychologist has not written to the doctor to advise of patient progress. This financial penalty is more likely to improve communication between psychologists and medical practitioners than is the introduction of a third party (ATAPS administrators) in this relationship.

Secondly, the ATAPS program may not be able to effectively treat the most severe and complex mental health cases. This could occur through market forces to do with supply and demand principles. That is, ATAPS is likely to employ psychologists at a lower rate of pay in order to reduce costs, perhaps with the aim of delivering a larger number of sessions to clients. These pay rates will attract the least experienced and the least qualified psychologists, without a specialisation in clinical psychology, because the relatively long and expensive post-graduate training required for clinical psychologists tends to result in a higher salary.

The outcome of this is that those with the most severe mental health problems could end up being treated by psychologists without specialised clinical training and experience. In addition, ATAPS funds available for direct patient treatment are reduced because of the cost of people employed to administer the program, ultimately leading to fewer per-patient sessions.

(e.i) The two-tiered Medicare rebate system for Psychologists

In 1989, the Management Advisory Service to the NHS differentiated the health care professions according to skill levels. 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).

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.

The group 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..."

In other words, when compared to generalist (also called “registered”) psychologists, clinical psychologists have been found, by the government’s own agency, to have additional skills and knowledge.

This is because clinical psychologists are uniquely trained to treat people with complex and severe mental health problems. Clinical psychology is the only profession, apart from psychiatry, whose entire accredited and integrated postgraduate training (either two or three years full-time) is specifically in the field of lifespan and advanced evidence-based psychopathology, assessment, diagnosis, case formulation, psychotherapy, evaluation and research.

Therefore, on the basis of broader skill sets and fair pay, it is not reasonable that the Medicare rebate for services delivered by clinical psychologists be equal to those services delivered by generalist psychologists.

References

Lambert, M. J., & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy, 38*, 357–361.