**Senate Community Affairs Committee inquiry into Commonwealth Funding and Administration of Mental Health Services**

This submission addresses two issues:

1. The impact of changes to the number of allied mental health treatment services for patients under the Medicare Benefits Schedule
2. The two-tiered Medicare rebate system for Psychologists.

**Changes to the number of allied mental health treatment services**

I am writing as a concerned Clinical Psychologist to bring to your attention to the problems arising from the Government's proposal to cut yearly Medicare sessions for Psychologists from 12 (plus 6 in exceptional circumstances) to a maximum of 10 sessions. As a Clinical Psychologist, I believe that the outcome of this proposal will be that the quality of care of clients will be severely compromised and the long term costs to the government will actually increase. It is of vital importance that the 10 session limit being imposed on psychological consultations in *Better Access* be reconsidered before it is put in place.

When this program was introduced, it was quite rightly limited to "evidence based" treatment. However, this evidence base is from treatment protocols typically of 12-16 sessions, not including the time allowed for assessment to devise an effective treatment program. The plan to cap psychological treatment at 10 sessions, falls below standard treatment protocol for the management of even the most uncomplicated psychological conditions. More complicated, chronic conditions require more sessions.

For example, one of my areas of speciality is obsessive compulsive disorder (OCD), an anxiety disorder which effects 1-2% of the population. The main treatment options are Cognitive Behaviour Therapy (CBT) or medication. While pharmacotherapy is effective in the treatment of OCD, only 40-60% of clients respond to it (McDonough, 2003) and it produces only a modest improvement (20-40%) in symptoms (Abramowitz, 2005), whereas around 75% of those treated with CBT improve significantly (Kyrios, 2003), typically with a 50-70% reduction in symptoms (Abramowitz, 2005). Further**, medication** often has unwanted side-effects and **requires indefinite continuation** to prevent relapse (Abramowitz, 2005; McDonough, 2003).

In the 2007 American Psychiatric Association *Practice guideline for the treatment of OCD,* the implementation of CBT is discussed, and concludes that "**expert consensus** recommends **13–20 weekly** sessions for most patients." (p. 12). Moreover, assessing complex conditions such as OCD typically requires at least two assessment sessions before commencing treatment to provide necessary information about all the rituals (overt and covert), triggers of rituals and avoidance patterns so a CBT program to address it can be developed. Information from a GP assessment is not adequate for this. I recently successfully treated a woman suffering from OCD who was pregnant and so unable to take medication for her

OCD. I could not have treated her successfully if only 10 Medicare sessions had been available.

New research (Harnett, O'Donovan and Lambert, 2010) on the number of sessions of psychotherapy needed for clients suffering from psychiatric illness to return to a normal state of functioning or reliably improve revealed that for 85% of people to show clinically significant change in their level of symptom severity, **around 21 sessions** of treatment was required. This research demonstrated that with 8 sessions of treatment, around half of people will need more psychological care to improve. The number of treatment sessions recommended for OCD is fairly typical of most anxiety and depressive conditions. Limiting the maximum length of treatment at 10 is plainly unrealistic and will set many people up for failure in the system.

As a cost cutting move, this is likely to achieve the very opposite, as it will lead to **increased costs** to the government. For example, I am treating several clients with serious conditions that are more complicated than OCD, such as, Depression with chronic suicidal ideation and Post Traumatic Stress Disorder (PTSD). The clients are very concerned that their treatment will now be cut short. They will have to be referred to a Psychiatrist – which will cost the government more in rebates on a per visit basis. Moreover, many clients prefer not to see Psychiatrists as they want CBT and other therapy rather than the medication psychiatrists are more inclined to offer. Without psychological therapy, they will probably be prescribed antidepressants and will need to be on them long term, which will also result in increased costs to the government.

Psychological therapy has been shown to reduce relapse rates in chronic mental health conditions. For example, in persons with more than three episodes of depression, Mindfulness-Based Cognitive Therapy has been shown to reduce relapse rates by half (Ma & Teasdale, 2004). Reducing relapse rates reduces both direct treatment costs as well as the much greater indirect costs of lost productivity and increased demand on all types of health services.

Clients with mental health conditions need a **viable alternative to medication** and Clinical Psychologists are the profession best placed in terms of training and expertise to provide this, particularly as much of professional development training for Psychiatrists is sponsored by Pharmaceutical companies with a vested interest in promoting medication rather than psychotherapy. A smart government would be putting their mental health resources into evidence based psychotherapy that teaches coping strategies and reduces relapse rates and decreases reliance on medication, rather than a system that leads to long-term dependence on medications.

The argument that if more than 10 sessions is required, they can be referred to a Psychiatrist is also questionable as I am often referred clients by Psychiatrists who do not have the expertise to treat OCD or PTSD with psychotherapy. It has also been argued that statistics show that more than 12 sessions were rarely taken up and so are not necessary. However, what this demonstrates is that more than 12 sessions have only been used when absolutely necessary, most likely for the more complex conditions. It does not make sense to take this option away when it has only been used on a limited basis.

The Better Access Program has delivered quality care that has been shown to be both efficacious and cost-effective. It is somewhat ironic that it is a Labor government that is rolling back this important health care initiative. This proposal by the government will apply pressure to both clients and the Psychologists they consult with, to achieve results over an even briefer period of contact. This expectation is unrealistic and unfair to those who are already suffering and struggling with their debilitating condition.

**The two-tiered Medicare rebate system for Psychologists.**

The two-tiered Medicare rebate system for Psychologists should be maintained as it recognizes the superior training and skills of Clinical Psychologists over those who have not undergone the additional university and supervised practice required for Membership to the College of Clinical Psychologists. Just as Medical specialists have their years of extra study and more specialised training and expertise recognized in the Medicare rebate system, Clinical Psychologists should also have their specialist skills recognized. The public and referring doctors need some way of identifying which Psychologists have this substantial additional training.

I, like any Psychologist with many years of experience doing clinical psychology work, but without a Clinical Master's degree, was initially classified as a "Generalist" and given the opportunity to have my qualifications and experience assessed. Following this assessment, I took up the opportunity to do a two year bridging plan of study (involving further university based study, extra supervision, assignments and case studies) so as to meet the high standards required to qualify as a "Clinical Psychologist". All "Generalist" Psychologists with the years of relevant experience in clinical psychology were given the opportunity to have their training and experience assessed, and if appropriate, to proceed with a bridging plan to gain recognition of their years of experience.

The Medicare evaluation purporting to demonstrate similar outcomes with Generalist and Clinical Psychologists had multiple research methodological flaws and was not peer reviewed. The methodological flaws included not identifying the nature, diagnosis or complexity of the clients seen by which type of Psychologist; not having follow-up assessments of clients to compare outcomes and assess relapse rates by type of Psychologist; and not having a valid criterion measure applicable to a range of diagnoses with varying complexities so that pre and post conditions of clients could be meaningfully compared.

At the simplest level, a "Clinical" Psychologist, as opposed to a "Generalist", must have a Masters qualification or the equivalent therof. To fail to recognise the greater knowledge and skillset of Clinical Psychologists brings into question the very essence of higher education. Why should the Masters programs offered at Australia's most venerable Universities continue to exist if their graduates will not be recognised by the system as having furthered their clinical skills? The implications of the are far-reaching and question the integrity of our education system.

Many clients have complex presentations, often with co-morbid conditions. The process of diagnosis, assessment and formulation is essential for the effective

management of complex mental health disorders. Other than psychiatry, Clinical Psychology is the only mental health profession whose complete post-graduate training is in the area of mental health. No other allied mental health professional receives as high a degree of education and training in mental health as the Clinical Psychologist. If funds for treatment of mental health conditions are limited, they are best directed to those who are trained to conduct thorough assessment, clinical evaluation and diagnosis of individuals with complex mental health problems, i.e. to fund treatment conducted by Clinical Psychologists.

While Generalist Psychologists may be able to treat mild to moderate, simple and uncomplicated presentations of anxiety and depression, Clinical Psychologists are trained to treat more complex presentations such as suicidal and chronically self-harming individuals and those suffering from conditions such as depression or anxiety that are co-morbid with personality or substance abuse disorders. Referring doctors need some way of identifying which Psychologists have the added expertise and training to deal with more complex presentations and the two tier system allows them to do this. Just as Psychiatrists are the specialists trained and experienced in the widest range of psychotropic medications, Clinical Psychologists are the specialists trained in the widest range of psychotherapies, beyond the focused psychological strategies which are often not enough for more complex presentations.

**In conclusion**, I urge you to investigate this proposal for the *Better Access* initiative and leave the length of treatment intact at 12-18 sessions as a 10 session cap is inadequate and will lead to increased costs for the government.

The two-tiered Medicare rebate system for Psychologists recognizes the superior training and skills of Clinical Psychologists and enables referring doctors to identify those with the skill-set for helping those people with more complicated, co-morbid conditions that are otherwise a significant burden on the Australian health-care system.

Thanking you for your considered attention to this matter

Sincerely,

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