Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600
Australia

Dear Sir/Madam,

Re: Submission to the Senate Community Affairs Reference Committee - Commonwealth Funding and Administration of Mental Health Services

I am a clinical psychologist who has a bulkbilling private practice in a socioeconomically deprived area of Logan, Queensland. I would like to make a submission expressing my concern regarding the changes made to the Better Access scheme in the recent budget, notably the decision to reduce the possible number of sessions from between 12-18 to only 10 sessions per calendar year. I would like to stress that this submission is not made out of self interest, or a concern that my income will be affected by the recent changes to the Better Access scheme. Because our practice is in an area of high need, where most if not all clients lack the means to pay for psychological treatment, we have more referrals than we can accommodate, and our income will be in no way reduced by the changes.

The government's decision to reduce the possible number of treatment sessions appears to have been based purely on cost considerations, and no attention has been given to the available empirical findings regarding the amount of psychological treatment required to bring about positive outcomes (by scientific standards the methods used in the recent review of the Better Access scheme were very shoddy, and its findings cannot be relied upon to inform decision- making).

There is a body of research which identifies the optimal number of treatment sessions to facilitate meaningful change in psychotherapy (see references). A review of the literature indicates that between 11 and 16 sessions are required for 50% of clients to attain clinically significant change (Hansen, Lambert, & Forman, 2002). A standard of 75% of patients attaining clinically significant change would be a more compassionate target, and to achieve this, a standard of 25 sessions would be reasonable (Anderson & Lambert, 2001).

Most patients who receive 10 sessions or less would not receive enough treatment to reach even a moderate level of clinically significant change. Limiting psychotherapy to only 10 sessions for all clients is particularly disadvantageous to the most disturbed clients, whose time to recovery is slower and who are at most risk of self harm and social and occupational disengagement.

It makes little sense to under-serve individuals whose pain and pathology are greatest, while appropriately caring for individuals whose distress and suffering are only mild to moderate. This is a little like triaging people with only mild injuries to get immediate, gold standard care, while leaving those with life-threatening injuries to be sent home with a few aspirin.

An argument has been made in some quarters that individuals with more serious psychological disorders and distress receive treatment and care from other agencies or services. Having worked both within a Queensland Health mental health service, as well as in private practice, I can attest to the fact that state mental health services do not have the capacity to deal with the severely distressed clients presently seen in private practice. Their resources are already inadequate for dealing with their "core business" i.e. clients with severe mental illnesses such as schizophrenia and bipolar disorder. Clients who present to community mental health centres with disorders such as severe depression, anxiety and post traumatic stress disorder are usually quickly referred on to private practitioners. Some critics of the Better Access scheme have implied that it has wasted resources on the "worried well". These individuals are ill-informed. The majority of clients seen with our practice and most other practices with which I am familiar in the Logan area present with moderately severe to severe, complex psychological disorders, often with two or more co-morbid conditions. In many instances, the Better Access scheme has offered these individuals their first opportunity for treatment after decades of suffering.

I propose that cost savings could effectively be made in other areas, without the need to jeopardize the recovery of the mentally ill. Two possible sources of cost savings could be diverting the money from the school chaplaincy program to this much more significant area of need, and removing the need for a GP review following 6 sessions of treatment by a psychologist.

Yours sincerely

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Clinical Psychologist

<u>References</u>

Anderson, E.M., & Lambert, M.J. (2001). A survival analysis of clinically significant change in outpatient psychotherapy. *Journal of Clinical psychology*, 57, 875-888

Hansen, N.B., Lambert, M.J., & Forman, R.V. (2002). The psychotherapy dose-response effect and its implications for treatment delivery services. *Clinical Psychology: Science and Practice*, 9, 329-343

Kadera, S.W., Lambert, M.J., & Andrews, A.A. (1996). How much therapy is really enough? *Journal of Psychotherapy Practice and Research,* 5, 132-151