Commonwealth Funding and Administration of Mental Health Services

Dear Committee Members,

I very much appreciate the opportunity to present my concerns. I wish to address the following points from the Terms of Reference:-

(b) (iv) - the impact of changes to the number of allied mental health treatment services for patients with mild to moderate mental illness under the Medicare Benefits Schedule;

(c) - the impact and adequacy of services provided to people with a mental illness through the Access to Allied Psychological Services program.

(e) (i) - the two-tiered Medicare rebate system for psychologists;

*In relation to **item (b)(iv)** I am concerned that:-*

1. The reduction in session numbers from 18-10 (not 12-10) will create a service gap rather than "better access".

I am a Clinical Psychologist with 15 years experience (9 years in full-time private practice) in the regional town of Launceston - population approximately 70,000. Previously I was employed as one of eight multidisciplinary clinicians (3 psychiatrists, 2 clinical psychologists, 3 allied health) in the Psychiatry Department at the local general hospital which provided state-funded outpatient services for three broad patient groups: -

1) Post-admission patients with debilitating and persistent mental illness and complex needs (e.g. Schizophrenia; Anorexia Nervosa; pharmacologically resistant Bipolar Disorder; drug-induced psychosis [recurring admissions due to addiction]);

2) Post-admission patients experiencing acute episodes who required short to medium-term inpatient care, but more importantly, intensive outpatient follow-up of up to 45 treatment sessions per year (e.g. Bipolar Disorder; extreme cases of Obsessional Compulsive Disorder where the patient felt they might harm others for example; acute suicide risk associated with Posttraumatic Stress Disorder, Major Depression or Personality Disorders);

3) The type of mental health disorders that I now treat in my private practice e.g. Major Depression, Eating Disorders, Panic Disorder & Agoraphobia, Adjustment Disorders, Alcohol Use Disorder, Chronic Psychotic Disorder, Mixed Anxiety and Depression, Sleep problems, Dissociative Disorders, Conversion Disorders, Personality Disorders, Generalised Anxiety Disorder, Social Phobia, Posttraumatic Stress Disorder, and Obsessional Compulsive Disorder. Usually these patients were referred by their GP just as they are under current Medicare arrangements.

In addition to the clinicians employed in the hospital setting there were at least four psychiatrists in private practice (currently two part-time) and a community crisis team that provided assessments for hospital admission and counselling services. The role of the crisis team has been severely curtailed and the hospital psychiatric outpatient treatment team was disbanded for a case management model about 7 years ago. Case management does not provide outpatient treatment for patient groups 2) and 3) above. Therefore, there is no “state service” for such patients (pg. 22 Budget National Mental Health Reform 2011-12), and most of these people experienced a service gap until the Better Access initiative began as they could not afford to see a private psychologist.

In addition to the previously mentioned patients, the introduction of the Better Access scheme encouraged a large and previously invisible group of people in the region to access psychological services for the first time. They did this because they felt the process better respected their privacy (crucial and difficult to achieve in small towns), was less visibly bureaucratic, was less likely to be stigmatising and was affordable. Despite their lack of previous contact with mental health services, people in this new group suffered surprisingly often from quite debilitating conditions. Clearly, the Better Access scheme has dramatically extended the reach of mental health services in this region.

If the maximum treatment sessions through Better Access are reduced from 18 to 10, then I am concerned that a significant service gap for the groups identified above will re-emerge. These people suffer from conditions that are treatable but usually require more than 10 sessions to be effective and to provide long-lasting change. They often suffer unnecessarily, living lives of unfulfilled potential, experiencing inexplicable sadness or anxiety or anger or mental and social isolation or combinations of the above. Nevertheless, they do not need or want psychiatrist involvement, Care Facilitators, Personal Helpers, Mentors or state-based crisis services.

2. Any dismantling of *Better Access* would be irresponsible if based upon the crude evidence cited.

The Federal Government argues that treatment sessions can be reduced to 10 sessions because “the average number of allied health services received after a GP Mental Health Treatment Plan is five.” (Pg. 22 *Budget National Mental Health Reform 2011-12*).

It is important that significant cuts are not based on one figure – as the *average* quoted is not at all informative about many important matters including outcomes or need. For example, the Australian Psychological Society conducted research based on 9,900 patients who received more than 11 sessions under Better Access (i.e. a sample of those who will actually be affected by the reduction of the permissible sessions from 18 to 10). Patients in the sample overwhelmingly suffered severe levels of depression or anxiety disorders, including PTSD. Pre-treatment, 84% experienced *moderate to* *severe*, or *severe* symptoms with 43% having co-existing additional mental health disorders, such as personality disorders or drug or alcohol dependency. After 18 sessions only 3% remained severely affected, while 43% were symptom free, or experienced only mild symptoms. On this evidence it appears that *Better Access* is probably a highly cost-effective program and that a large number of people will be potentially adversely affected by the proposed changes. Indeed it may be that the best and most durable outcomes are achieved when a greater number than 10 sessions is delivered. This would certainly better match CBT research findings.

I also note that the proposed caps are justified on the basis that “87 per cent of current Better Access users receive between one and 10 services and will be unaffected by this change.” (Pg. 22 *Budget National Mental Health Reform 2011-12*). It is entirely possible that a significant number of these users received sessions in the previous or previous years (potentially a full quota of therapy i.e.18) and as a result now need fewer sessions (current average 5) to maintain their mental health. This is unknowable from the Medicare data presented but important to discover.

What remains *unclear* is how provision of these extra sessions through psychiatrists, or other programs (that presumably include additional bureaucracies and employ fully qualified professionals), will be able to deliver more services which are better targeted at the above patient group (individuals requiring more than 10 allied health services sessions - who will still need to access services) and save money. The rebate for Medicare-subsidised psychiatrist consultations, is currently more than double that provided to psychologists. The funding to be made available will come from cost savings associated with only 5% of patients who received 13 to 18 sessions of therapy (and must therefore be negligible savings) according to Medicare data.

3. The Better Access caps to treatment sessions are based on research that contradicts the recommended CBT treatment sessions for various disorders (i.e. the very treatments which underpin the system).

As far as I am aware, there are no evidence-based treatments of six to ten sessions for moderate Depression, PTSD, Obsessional Compulsive Disorder, Generalised Anxiety Disorder, Social Phobia, Panic Disorder and Agoraphobia, to name just a few. Treating such conditions is a clinical psychologist’s core business and what we have been trained to do – it is not the domain of psychiatrists, as their training is not steeped in cognitive behaviour therapy. In Robert Leahy & Stephen Holland (2000) *Treatment Plans and Interventions for Depression and Anxiety Disorders* it states that for most of the above mentioned conditions, recommended treatment length is 20 sessions (see Appendix 1). According to Butler & Beck (1995) [*The Clinical Psychologists* 48(3), 3-5] many patients show remission of depressive symptoms in 8 to 12 sessions but further sessions are used to evaluate and modify dysfunctional beliefs that impair functioning, and make the patient vulnerable to future depressive episodes. I believe the new cost cutting measures will prove to be a false economy if patients, due to caps on sessions, are unable to:- build adequate relapse prevention skills; consolidate treatment gains; and access booster sessions.

Finally, I believe it is unethical and unsafe to begin evidence-based treatments in the knowledge that there is inadequate time available to complete the treatment. For example, I would not even begin a trauma-based exposure therapy, (which is recommended treatment when a PTSD patient is experiencing flashbacks and nightmares) if only 10 sessions were available. There would be inadequate time to develop rapport, complete an assessment (with specific regard to patient risk factors that would alert the therapist to potential hazards involved in the treatment), have a full understanding of the nature of the trauma/s, win the trust of the patient, explain the rationale, and then safely guide a vulnerable patient through a most demanding intervention. It is of great professional concern to know that one has to waive treatment, or prematurely halt treatment, knowing that the client will continue to suffer unnecessarily. These patients require the maximum treatment sessions under Better Access (or even more), not a 45% reduction.

*In relation to **item (c)** re ATAPS:-*

It has been rumoured that patients requiring more than 10 sessions might be treated through ATAPS services in this region. ATAPS locally is currently rolled out through the GP Network, which attracts mainly new psychology graduates and other allied health professionals by providing them with good exposure to a variety of clinical cases and contracting supervision by other more senior psychologists. It would be of major concern if the least experienced clinicians were found to be treating the most severe conditions.

*In relation to **item (e) (i)** (the two-tiered rebate system for psychologists). I am concerned about the possibility of a reduction in the Medicare rebate available for clinical psychologists.*

This measure would have a profound impact on:
1) The cost of psychological therapy for patients;
2) The economic viability of clinical psychologists;
3) The supply of clinical psychologists;
4) The development of new psychological techniques;
5) The type of psychological services delivered which would skew towards psychological *strategies* rather than psychological *therapies*.

Points 1 & 2:-

Costs will increase for patients as the gap between the Medicare rebate and the clinician's fees widen, if the clinician is to remain economically viable. The current APS recommended fee for a 45-60 minute consultation with a psychologist is $218. This rate assumes productivity of 66% i.e. the ratio of billable time to non-billable time, and is thus equivalent to $144 per hour. The current Medicare rebate for this consultation is $120. The proposed rebate before the Senate committee is $80 per 50-60 minute session or effectively $52.80 per hour using APS assumptions. Under Medicare, however, cancellations are a financial risk carried by practitioners and cancellations amongst this cohort can be ruinously high. But any cancellation will constitute a large percentage of a clinical psychologist's costs as only 5 hours are able to be billed per normal 8-hour working day (at a productivity rate of 66%). A single cancellation therefore, of a Medicare patient would reduce the daily income to $40 per hour. Assuming a 30% tax rate and 30% business running costs, the gap passed on to patients is likely to be considerable. If patients are not prepared to pay this gap fee from their own pockets then there will be an attrition of therapists in the region and access to mental health professionals will diminish.

In July of 2011 the local GP Network, which had provided bulk-billed Medicare Psychology services, advised by letter that it had 'always been significantly oversubscribed … and could no longer deliver Psychological Services … due to the fiscal difficulties we experienced in maintaining it'. Clearly the Medicare rebate was insufficient to run a sustainable business without imposing a considerable gap fee.

Point 3:-

Were the suggested reductions to the rebates available for clinical psychologists to take effect then clinical psychology would have little or no raison d'être. In the absence of appropriate financial incentives, to undertake the onerous additional study and professional training requirements of a clinical psychologist would be irrational. The demise of the profession would likely follow.

Point 4:-

As psychology is a discipline it has a unique body of knowledge. An important (if not the most important) method of building the body of knowledge is through original research undertaken by Masters and Doctoral students. Although the minimum qualification for a clinical psychologist is currently a Masters Degree, it is anticipated that that minimum will eventually become an even more rigorous PhD as is the situation elsewhere. However, if the career path for clinical psychologists is removed or limited to universities and public institutions, then the volume of original, high-level psychology research will diminish and Australian development and evaluation of therapeutic techniques will stall. This would be disastrous and ironic, because the vast majority of Medicare approved psychological strategies utilized by allied health care professionals and psychiatrists are derived from, and on loan from, the body of knowledge called psychology. In this sense, clinical psychologists make the most important contribution of all to the Better Access program and are critical to its evolution. They should be encouraged to continue contributing through proper and adequate remuneration.

Point 5:-

Any cuts to rebates will introduce uncertainty and affect the viability of many small psychology businesses. Most will attempt to adapt in some way but the consequences are unpredictable. The most fruitful strategy other than to change profession or leave the business would be to increase the number of billable hours. This might be achieved for example by reducing the amount of unpaid administrative work (simplifying unpaid GP correspondence, minimizing treatment planning, reducing unpaid co-ordinating or advocacy functions) and accepting relatively “easy” referrals based on the nature or complexity of a patient’s condition i.e. what is likely to have the least impact on a therapist’s stress levels and thus, their own long-term mental health, combined with the highest throughput (e.g. accepting referrals that might involve well-rehearsed “strategies” rather than challenging and taxing “therapy” with potentially “at risk” clients). Ironically, this could invert the current system entirely as I would be reasonably confident that given a choice, and other things being approximately equal (rebates and gap fees), patients will seek the services of a clinical psychologist over other allied health professionals (for no reason, necessarily, other than that they are perceived to be mental health specialists). Given first choice in circumstances of equal rebates a clinical psychologist would rationally choose the patients with the least complex conditions (hoping for greater throughput and thus enhanced financial viability), leaving severe, distressing and complex cases and therapies to others – no doubt yet another unintentional consequence but one that would truly invert the current system.

Yours sincerely,

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Appendix 1

TREATMENT DURATIONS

Reference: Treatment Plans and Interventions for Depression and Anxiety Disorders. Robert Leahy & Stephen Holland (2000). Guilford Press.

Disorder	Treatment Duration	
Depression	**20**	*Within 20 sessions approximately 75% of patients experience a significant decrease in their symptoms.*
Panic Disorder & Agoraphobia	**20-25**	*Over a course of 20 to 25 sessions the efficacy rate ranges from 85 to 90%*
Generalised Anxiety Disorder	**20**	*About 50% of patients with GAD show significant improvement.* (No statement is made in the client handout about the number of sessions but the treatment plan calls for 20 sessions).
Social Phobia	**20**	*For people with mild to moderate social phobia 20 sessions is usually enough. People with fear of just one social situation may need fewer sessions. People with more serious symptoms may need more.*
PTSD	**12-20**	*How long treatment for PTSD lasts depends on how many traumas you suffered and how severe they were, how bad your symptoms are now and how many other problems you are having in your life. For people who have been through a single traumatic event 12 to 20 sessions are usually enough.*
Specific Phobia	**3 hours of exposure**	*Many patients are able to improve rapidly with a few prolonged sessions (2-3 hours) that allow intense exposure to the feared objects or situations. Depending on the fear between 74% and 94% of patients improve when they use these techniques.*
OCD	**20**	*Cognitive behavioural treatment for OCD usually takes about 20 sessions. Treatment may take longer for people with severe symptoms.*