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## **The Senate Community Affairs Reference Committee Inquiry into Commonwealth funding and Administration of Mental Health Services.**

I write in reference to

(a) The Government's 2011-2012 Budget changes relating to mental health

(b) Changes to the Better Access initiative, including

(ii) Rationalization of allied health treatment sessions

(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

Access to Allied Psychological Services program

(d) Services available for people with severe mental illness and the coordination of those services

(e) Mental health workforce issues including

(i) The two-tiered Medicare rebate system for psychologists

Dear Sirs,

### **Rationalisation of allied health treatment sessions.**

### **The impact of changes to the number of allied mental health treatment services for patients with mild or moderate mental illness under the Medicare Benefit Schedule.**

I am writing to request urgent review of the proposed changes to the Better Access Scheme as outlined in the 2011-2012 Federal Budget. As a clinical psychologist I have specialized training and experience in the assessment and treatment of mental health disorders, across the spectrum of mild, moderate and severe presentations.

Whilst I applaud many of the new mental health initiatives outlined in the Budget, I have serious concerns about changes that reduce patient access to treatment by Clinical Psychologists and reduce the overall quality of service provision, particularly for those patients with moderate-severe mental disorders and/or significant comorbidity.

My concern stems principally from the fact that Clinical Psychologists are specifically trained to work with patients who have complex mental health issues. The February 2011 Better Access Evaluation Report prepared by the University of Melbourne confirmed that Better Access delivered a large number of services using evidence-based treatments. Half of the patients

treated had not before received mental health care, and most of them had diagnoses of anxiety and/or depression. However, I have been concerned for some time that this system was aimed at the treatment of mild cases, at the expense of moderate-severe mental disorders and/or significant comorbidity. The evidence from the University of Melbourne evaluation showed that 75% of patients received 1-6 sessions.

However, as a clinical psychologist I am routinely referred patients with moderate to severe disorders under the Better Access programme. I have been in private practice for the past 27 years and have a further 10 years of experience in the public sector. Since the introduction of Better Access my case load has become more complex because of the severity of the conditions that have routinely been referred to me. Many of the doctors who refer to me say that they only refer to me as I am a clinical psychologist as they tend to have more confidence in the outcome with their patients. They also feel free to discuss pharmacotherapy with me as they believe this is in the best interests of their patients.

It is unclear on what basis the decision was made to reduce the number of psychology treatment sessions a person with a mental health disorder can receive each year under the Medicare benefits schedule from a maximum of 18 to 10. No evidence base supporting the reduction in number of sessions was provided.

The government appears to have argued that the changes to the better Access Scheme will not affect large numbers of consumers as only approximately 13% of Better access patients receive more than 10 sessions. This however equates to around 86,000 (Lyn Littlefield CEO APS Life Matters 21/6/11) patients per annum, all of whom are the more vulnerable amongst those with mental health problems. While the government states that these people may obtain services under the ATAPS program, the public health system or from private psychiatrists; these options are not necessarily suitable for this group of patients and are exceedingly limited.

I would strongly recommend that the 18 sessions including those for "exceptional circumstances" be reinstated under Better Access in the absence of a scheme that provides access to clinical psychology services for some of the more vulnerable members of the community. I would also recommend that the previous system of generally two sets of six sessions being available to most patients as a much preferred model. Whilst milder cases may be able to be treated within a six session model, it is condescending at best to think that moderate to severe problems can be dealt with anything like 12 sessions. Clinical psychologists such as myself possess the hospital and clinic-based training and supervised experience that is essential to ensuring the delivery of effective, comprehensive, evidence-based mental health care for patients with complex presentations.

In essence, I am greatly concerned about the capacity for Clinical Psychologists to provide high quality care under the changes to Better Access. In particular, I hold serious concerns regarding the capacity for treatment of patients with complex presentations and/or comorbid conditions, such as those patients presenting with personality disorders, substance abuse, and/or early trauma histories, as well as those with long-standing mental health issues and associated impairment in functioning, such as adults presenting with childhood-onset anxiety disorders, eating disorders, or longstanding obsessive compulsive disorder and/or depression that has not responded to medication. Indeed treatment may have unintended negative consequences for these patients if session limits require that treatment be ceased prematurely; for example, reinforcing long-standing patterns of isolation, rejection/abandonment and hopelessness. For these reasons I have serious concerns regarding the ethics of providing treatment to such patients referred to myself under the Better Access Scheme, if the new session limits are to be

implemented, whether it is in the public or private sector.

Clinical Psychologists have the training and skills required to assess and diagnose conditions when longer term treatment is required, select which treatment modalities are appropriate, provide sophisticated clinical psychology treatments, and know how best to integrate this care with treatment provided by other health professionals (such as psychiatrists, GPs, and other allied health providers).

Focused Psychological Strategies provided by generalist Psychologists and other allied health providers are particularly appropriate for consumers presenting with milder mental health conditions and no comorbid issues, where treatment is more straight forward and the total number of treatment sessions would be expected to be lower. Based on my reading of the Budget to date, it does **not** appear that a distinction has been made between these two levels of services – that is, Focused Psychological Strategies and Clinical Psychology Services. I believe that this is an important distinction, and that due consideration should be given to this distinction in planning mental health care, both within the private sector under Better Access, and within the public sector under other mental health initiatives.

**(e) Mental health workforce issues including**

**(i) The two–tiered Medicare rebate system for psychologists**

The two–tiered Medicare rebate system recognizes the value of accredited post graduate training in the specialty of clinical psychology for the provision of high quality service to those members of the public suffering from mental health problems. Qualified clinical psychologists are trained to be experts in the prevention, assessment diagnosis, formulation, treatment and evaluation of treatment outcomes for a wide range of mental health problems, at all levels of severity, across the lifespan. Only qualified clinical psychologists and psychiatrists have these levels of advance training. Any attempt to reduce the distinction between those with accredited post graduate training in clinical psychology and those without this training will act to remove incentives for such training, further undermine standards and lead to an exodus from the profession of the best trained clinical psychologists. Most importantly such a result would subject the public to a lack of trained and qualified clinical psychologists in the future thereby increasing the risk to the public. To not recognize the unique contribution of clinical psychologists would in my view also make a mockery of the university courses that have been set up to provide such high standards. I would strongly recommend the retention of the two tiered Medicare rebates system.

**Access to Allied Psychological Services program**

**(d) Services available for people with severe mental illness and the coordination of those services**

The efficacy of Focused Psychological Strategies as provided under the current ATAPS program short term treatment of mental illness is highly questionable given the 43% representation rate of patients to the Better Access program. ATAPS only provided Focussed Psychological services which are not specialized and are only suited to the mildest presentations.

The Better Access scheme under the current budget now distinguishes between mild, moderate and severe presentation and removes those with greater need from access to private treatment in their community by their choice of practitioner. Individuals with more severe illnesses are to be referred to

- 1) The ATAPS Program, which is limited in focus more expensive and restricted in choice for the consumer
- 2) To psychiatrists where there is a distinct shortage particularly in low SES and rural areas and a significant co payments are commonly demanded or
- 3) To the public sector which treats only those with the most severe and persistent mental health problems.

Therefore the more moderate to severe or chronic presentations require greater services, but under the changes announced will be provided with fewer options, greater restrictions and poorer access to services.

In my current division of general practice (which as I understand it is going to become a Medicare local), there are approximately ½ million people covering the cities of Booroondara, Whitehorse and Manningham. I note on the website that no further applications are being taken for psychologists to join this scheme. This therefore limits the GP's ability to refer to the psychologist of their choice under this scheme. Currently there is 1 occupational therapist registered, 11 social workers, 19 clinical psychologists and 86 other psychologists. If it is deemed appropriate as I would consider it to be then the majority of the cases with severe presentations should be seen by the 19 clinical psychologists who are registered as they would have the competency to deal with such complex cases. This would no doubt mean a considerable caseload for these practitioners and possibly considerable waiting times for clients to see them thus defeating the purpose to a considerable degree.

At the commencement of the ATAPS programme it was seen to be a more favorable option for a generalist psychologist as it paid a significantly higher rebate than that provided by Medicare. I however did join the ATAPS register and was not concerned about the lower fee as I felt that was part of my service to the community and I was prepared to see a proportion of my clients for a lower fee.

I also fail to see how at times some GP's will be able to recognize a complex issue. Often it may not be until the second or the third interview that complex issues will emerge. This is not a deficiency of the GP but rather that they do not have the time nor would one expect them to be able to diagnose complex issues which are not necessarily presented by the client.

Thank you for the opportunity to express my views to the committee.

Yours Sincerely

**Robyn Weir**  
**Clinical Psychologist**