

## **To the Senate Standing Committee on Community Affairs**

I submit the following in relation to the Government's funding and administration of mental health services in Australia, with particular reference to the Government's 2011-12 Budget changes relating to:

**(b) changes to the Better Access Initiative, including:**

- (ii) the rationalisation 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;**

As a clinical psychologist with more than 10 years professional practice experience, I am concerned at the potential impact of the proposed changes to the Better Access initiative in respect to the reduction in the maximum number of sessions allowable under typical circumstances (from 12 to 10) and the complete removal the exceptional circumstances provision of an additional 6 sessions. While meta-analysis of dosage rates for provision of psychological intervention often yields findings of an average of 6 sessions, it is well acknowledged within the field of statistics that an average is only accurately representative of the actual phenomenon in certain situations – such as where the population under study is relatively homogenous. Such is not the case within the mental health population. Consequently, I believe that both the rationale and the cited supporting evaluation study are flawed in terms of accurately reflecting the nature of the need for mental health that the Better Access initiative has been serving.

In contrast, there is an amounting array of robust research findings from the emerging field of neurobiological research that more accurately reflects the actual nature of the mental health domain. Firstly, such research has identified and validated that the human brain (a key aspect of an individual's emotions, cognitions and behaviours) is designed to function and change within a social context. This finding has provided the scientific 'evidence' in support of what has long been anecdotally recognised by psychologists – that sufficient provision of professionally informed 'therapeutic relationship' is frequently key to the achievement of lasting mental health improvements. In actuality, a substantial proportion of the patients that I have treated across my 10 plus years of practice have lacked access to healthy interpersonal relationships that support development and maintenance of improved mental health functioning. Rather, such patients tend to have social networks that, unfortunately, reinforce and maintain problematic mental health. The issue of continuity of care is also particularly supported by this key finding as too frequent a change of service provider (ie therapist) interrupts the necessary time that it takes (on the part of the patient) for formation of a sufficient degree of trust to enable the patient-therapist to become therapeutically effective.

A second and related finding from neurobiological research is the identification of the neurobiological basis of mental health 'behaviour' (including emotions, cognitions and actual behaviours) change. Specifically, in order to establish a new 'behaviour', 'new' neural pathways need to be established and 'old' neural pathways need to be 'degraded'. Research findings in this area of 'neuroplasticity' highlight the necessity of opportunity for sufficient repetitions of 'new' mental health behaviours to enable

them to be sufficiently established relative to the existing strength of 'old', well established ones. Failure to do so results in excessive relapse – which has been shown to also lead to development of loss of hope for an individual of their ability to achieve improved mental health functioning.

Patients who have good insight into their mental health functioning and who have adequate social support networks typically achieve substantial gains in relatively few sessions. Unfortunately, these patients do not represent the majority proportion of patients who typically are seen by psychologists – and particularly by clinical psychologists. Consequently, for a substantial proportion of patients, a greater number of sessions are required to provide the patient with a sufficient number of sessions to enable 'brain function' change at a biological level (ie neural pathway change) so that risk of relapse over time is reduced.

Having worked under the Better Access initiative as a clinical psychologist, I have been conscious of utilising this initiative in a responsible manner – aiming to use the least number of sessions to achieve a sufficiently robust outcome for clients. I believe that the wider profession has similarly aimed to do the same. Unfortunately, the proposed reduction of the maximum allowable session limits appears to be a negative response to the responsible utilisation of the Better Access initiative rather than an affirmation that this initiative has been used responsibly.

In light of the above, I would assert that the proposed changes to the Better Access initiative in terms of reduction of sessions (and the associated intended re-direction of service provision for moderate to severe cases to the ATAPS program), while seemingly consistent with the findings of the Better Access evaluation study, are actually contrary to the broader findings of research into psychological intervention efficacy.

I would also assert that the proposed changes are a substantial regression for a system that was providing substantially improved access to high quality mental health services. While funding is to be redirect to ATAPS places, the number of ATAPS places being catered for appears to be considerably less than the number of Better Access places being reduced (ie the number of patients who have accessed between 10 and 18 sessions within a twelve month period). Furthermore, it would appear that the ATAPS service delivery model would actually result in a lower direct patient benefit per dollar due to money that would be absorbed under a case-management model as well as the comparative cost of a session delivered by a psychiatrist compared with a session delivered by a psychologist.

In reality, an ATAPS model is best suited to patients with intractable mental health conditions that are primarily managed by medication. This is not the case with the majority of moderate to severe patients that have been able to be treated to date under the Better Access initiative. Many patients who experience moderate to severe levels of anxiety and/or depression (the most common presentations) are optimally treated using psychological intervention – either alone, or in conjunction with medication that is typically managed well by the GP. I have considerable doubts that the numbers of patients who would require intervention beyond the proposed new limits of the Better Access initiative would be able to be catered for – either in terms of numbers or in terms of the model of care provided – under the proposed ATAPS initiative. This is

particularly the case in the more immediate term until the ATAPS initiative is fully rolled out across – as I understand it – a five year term.

I also have particular concerns about the implementation of the proposed changes with respect to the inability of a patient who has accessed 10 or more sessions by Nov 1, 2011 to access any further Better Access session until January 1, 2012 – a two month period. For a not insignificant proportion of patients, the end of year/Christmas period is particularly difficult. Demand for provision of psychological services typically increases during this period. Anecdotally, the risk for suicide also typically grows at this point of the year. Consequently, the most vulnerable members of our society are at risk of being ‘cut off’ from what, for them, are essential services during a particularly difficult period. While this particular aspect of implementation of the proposed Better Access changes may make sense from a financial point of view, in terms of provision of mental health, it is actually grossly irresponsible.

In summary, I would assert that the proposed changes to the Better Access initiative in terms of the reduction in the number of allowable sessions from a total of 18 to 10 (and a corresponding proposed redirection of those affected to the progressively rolled-out ATAPS initiative) will result in:

- insufficiently robust interventions being provided to a substantial proportion of mental health consumers (in terms of insufficient duration of service delivery to achieve sufficient neural change and, therefore, lasting mental health improvement)
- insufficient available places for consumers who will be affected by the reduction in Better Access initiative session allowances and therefore will be redirected to the ATAPS initiative
- insufficient consistency of service provision to enable adequate ‘therapeutic relationship’ establishment for patients who would need to be treated under ATAPS instead of the present Better Access parameters (ie patients who need between 10 and 18 sessions)
- a less cost-effective service delivery model in terms of quality and quantity of service delivery under the ATAPS initiative
- the fostering of an increased risk of adverse mental health outcomes (including elevated risk of suicide) for consumers who will be denied access to necessary mental health services for the two months between Nov 1, 2011 and January 1, 2012.

**(e) mental health workforce issues, including:**

- (i) the two-tiered Medicare rebate system for psychologists,**
- (ii) workforce qualifications and training of psychologists, and**
- (iii) workforce shortages;**

I would propose the necessity of retaining the present two-tiered Medicare rebate system of reimbursement for psychologists under the Better Access initiative on the following grounds:

While clinical psychology is presently but one of a range of ‘endorsements’ under the new national framework of registration, it is nevertheless a unique specialisation that is the most specifically trained and equipped field of psychology for dealing the most

comprehensively with the mental health issues that are experienced by the majority of patients that are the focus of the Better Access initiative. Clinical psychology training (involving a minimum of six years full time university training plus two years mandatory professional supervision within the area of clinical psychology) is unique in terms of its degree of focus on (a) systematic assessment, (b) comprehensive formulation, (c) formal diagnosis, and associated (d) intervention development, implementation and evaluation. As a consequence of this unique and specific training, clinical psychologists have expert skills in piecing together the complex relationships between biological, social and psychological systems and transforming this analysis into effective treatments. Key to this transformation is the use of the 'scientist practitioner' model – a cornerstone aspect of clinical psychological training that develops clinicians as critically reflective practitioners who critically integrate theory, research and practice.

Because of the training and ongoing competence development of clinical psychologists, this endorsement/specialisation is unique in terms of its capacity to specifically assess, formulate and diagnose, not just whether a person has a particular disorder, but how that particular person specifically experiences that disorder and what is necessary in order to develop alternative, more constructive, ways of functioning for that particular person. Clinical Psychologists, through their specialised skills in functional analysis, have long recognised the importance of co-morbidity in the exacerbation and persistence of mental health deficits, and are trained to devise treatment regimens that take such key factors into account.

Because of the unique depth of focus upon understanding the complex phenomenon of cognition and behaviour change provided by clinical psychological training, clinical psychologists are uniquely positioned to understand and facilitate constructive intervention change – including identification of inherent 'barriers' to constructive change that a particular patient may experience. The identification and address of these barriers is a critical component in fostering effective change. Clinical psychologists are also uniquely trained in lifespan development which enables them to additionally locate a particular patient's mental health needs within their developmental context. Taken together, these abovementioned understandings, skills and capacities uniquely enable the clinical psychologist to incorporate and respond to the inherent complexity that is associated with mental health and mental health issues - particularly with respect to the uniqueness of such at the level of the particular presenting patient. In doing so, clinical psychology is unique in terms of its ability to undertake complex, yet comprehensive intervention that is aimed at maximising efficacy and longevity of a particular intervention – thereby minimising relapse and 'revolving door' re-presentation. This is particularly applicable where the particular patient's mental health issues are of a more severe and/or complex nature.

Unfortunately such differences will typically not be evident in short-term evaluation findings – but will become more evident with longer-term followup evaluation where lower relapse rates are revealed due to a more thorough and individually tailored intervention having been provided in accordance with the specialised training and competence of clinical psychologists.

In light of the above, I would propose that clinical psychology validly justifies its claim as a distinct specialisation that is more specifically trained and experienced than other areas of endorsement to addressing the mental health issues of a substantial proportion of patient's that are within the focus of the Better Access initiative in the

most efficient and effective manner. This is what the field of clinical psychology was established to do and what the training is specifically designed to achieve.

The present rebate level for clinical psychologists assists the financial viability of provision of high quality and high efficacy intervention. A downgrading of funding to clinical psychologists would signal to the public that there is in fact no difference between the qualifications and training of a clinical psychologist compared with either alternative endorsements or non-endorsed psychologists. There is already anecdotal evidence that the suggestion of the possible loss of the present rebate for clinical psychologist is leading undergraduate psychologists to question whether it is worth pursuing training in the field of clinical psychology if there is not going to be appropriate remuneration for such training and qualifications. With respect to the financial viability for existing clinical psychologists, a reduction in rebates will compromise such viability and will lead to the necessity to charge greater gap payments to patients in order to retain financial viability.

In summary, I have proposed that the training and qualifications of clinical psychology uniquely equips it to provide the highest quality and most efficacious mental health intervention to many of the patient's receiving mental health care under the Better Access initiative – although these differences are only likely to be identified via longer-term followup evaluation.

Thank you for the opportunity to provide comment to the Government's proposed 2011-12 Budget changes to the Better Access and ATAPS initiatives.

Sincerely

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