community.affairs.sen@aph.gov.au

31st July, 2011

Submission by

Nicolino Ramondo, MPsych (UWA)

Specialist Clinical Psychologist

Commonwealth Funding and Administration of Mental Health Services

Senate Inquiry: Community Affairs References Committee

I am writing to outline my concerns in regard to the proposed changes to the Commonwealth Funding and Administration of Mental Health Services.

My first concern is the reduction of the number of sessions provided under the Better Access scheme from a maximum of 18 to 10. In reality, it is a reduction of the standard 12 to six sessions, as most people could not access 18 unless there were 'exceptional circumstances'. No scientific evidence was provided to justify the reduction in number of sessions and this decision is actually contrary to the evidence base that does exist.

Many of the evidence based interventions employed by clinical psychologists require more than 10 sessions. For example, Cognitive Behavioural Treatments (CBT) for depression, PTSD, panic disorder and agoraphobia (to name a few) take up to 15 sessions. When personality variables are involved – such as when individuals have diagnoses of Borderline Personality Disorder (BPD) –this number increases. Indeed, the UK's NICE clinical guidelines for BPD, for example, discourage the commencement of a therapeutic relationship for a duration of less than 6 months, otherwise the interaction could be potentially damaging to the patient (e.g. abandonment experience, increased risk of self harm and suicide). The fact is that six (or 10) sessions are often not enough to carry out a proper intervention – especially when best practice suggests comprehensive assessment (which could take two or more of these sessions). It may be enough to provide some psycho education about cognition and/or very short term supportive counselling. However, it's not psychological treatment; it's a brief therapeutic intervention at best, and a akin to a band aid solution at worse. Some symptoms may be addressed in the short term but underlying factors that contribute to the illness are not. This means that relapse is more likely to occur and this will result in additional costs (financial, personal and social) to the individual and the system.

The reduction in the number of services provided under the Better Access program will affect approximately 86,000 people with more severe mental health problems. The plan that these people, if required, can access additional help through other sources is flawed. First, the ATAPS program is restricted to the provision of only Focussed Psychological Strategies which is inadequate to meet the treatment needs of those people suffering more severe presentations. Second, to see private psychiatrists is not a viable option as there are insufficient numbers of these clinicians resulting already in long, long wait lists, and they charge far higher co-payments. Third, the public health system caters only for the most severe and persistent presentations, and again there are long wait lists. In WA, where I live, there is a good public mental health system but the current state government is taking away public sector roles and devolving services to the private sector where services can be provided at lesser cost by less trained and qualified people such as counsellors. What that means for mental health patients is that agencies (for example church based agencies) who employ less qualified people will obtain the funding. Thus access for people with severe mental health problems to Clinical Psychologists is further restricted.

I have further concerns about the possibility that the existing two tiered system within Better Access could be dismantled. The two-tiered Medicare rebate system needs to be retained as it recognises the value of accredited post-graduate training and specialisation in clinical psychology. State and Federal awards differentiate between clinical and other psychologists, identify the differences in skill sets and the kind of work done by the two groups. Simply being "a psychologist" is not enough. Undergraduate training programs in psychology do not provide much more than overviews of psychological theory and assessment. There is no treatment focussed teaching in under-graduate programs and no clinical placements where the aspiring clinician learns to work patients. This only happens at Master's of PhD level. Removal of a two-tiered system will mean that individuals without comprehensive clinical training will be in a position to be rebated for working with patients presenting with moderate to severe mental health issues. Ultimately, it is the patient's well-being that I am most concerned about.

I also note that the 2011-2012 Budget transferred funding from the provision of private psychological services for all age groups and levels of severity of mental illness, into public sector child and youth mental health programs for the most severely affected. While I agree that early intervention and prevention program certainly need funding, I am most concerned that this is at the expense of an ageing population which has significant mental health care issues that are not being addressed adequately with funding either privately or publicly.

In conclusion, I am concerned that reducing the number of sessions, removing the two tiered system, and transferring funding will adversely impact upon mental health consumers and the provision of mental health services at both a private and public level.