

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

Dear committee members,

Thank you for inviting submissions for the Senate Community Affairs Reference Committee inquiry into 'Commonwealth Funding and Administration of Mental Health Services'. This brief submission aims to address specific points included in the Terms of Reference:

- (b)(ii) the rationalisation of allied health treatment sessions;
- (b)(iv) the impact of the changes for the number of allied mental health treatment services for patients with mild or moderate mental illness under the Medicare Benefits Schedule;
- (d) services available for people with severe mental illness and the coordination of those services; and
- (e)(i) the two-tiered Medicare rebate system for psychologists.

This submission advises that:

- Changes to the number of available sessions will make little difference to those individuals with **mild** degrees of mental illness but will impair significantly access to appropriate service for individuals with **moderate** and **severe** mental illness;
- Clinical psychologists are in a unique position to coordinate and implement services for the moderately and severely mentally ill, and;
- That the two-tiered Medicare system needs to be maintained and the specialisation of Clinical Psychologists needs to be recognised in an ongoing way.

Introduction

My name is Dr. Timothy James Doyle. I am a registered Clinical Psychologist in private practice in Melbourne, Victoria. I completed my undergraduate B.A(Hons.) degree with a major in Psychology at the University of Melbourne in 1997. I completed my professional postgraduate Doctorate of Clinical Psychology degree at Deakin University in 2005. I have subsequently worked for the majority of my time in the public mental health services. I have recently moved to private practice on a full-time basis.

I was moved to provide this submission by a range of concerns I hold about mental health service provision. I spent the first eight years (three in the Doctorate and five years employment) of my professional life training and working within the public mental health system. For the last three of those years I worked 'privately' one day a week; my move into full-time private practice has only

occurred as of December, 2010. I have worked for two public hospital networks in the roles of 'case manager' and as a stand - alone Clinical Psychologist on an Adult Psychiatric Inpatient Unit. I have been part of two structural reorganisations, seen dozens upon dozens of clients and have a well rounded understanding of the strengths and weaknesses not only of psychology but the other disciplines with whom I worked in the multi-disciplinary environments of the public system (e.g. psychiatry, nursing, occupational therapy and social work).

The public system is too restrictive in terms of its intake criteria to meet the broader needs of the community. This created a problems: there was a lack of adequate access to effective treatments for members of the community suffering from mental health problems that did not meet the criteria of acuteness, severity or extreme functional impairment required for access to the public mental health services. Mental health problems went largely unaddressed until they worsened so significantly that public service involvement was warranted. The functional impact of illness on sufferers' personal, occupation and family life was unaddressed. The suffering in the community was very real.

It was access to specialist treatment that the 'Better Access' scheme was designed to address. The Better Access scheme helped improve access for the treatment of common mental health disorders – anxiety disorders, mood disorders and adjustment disorders in particular. Furthermore, it facilitated a transition for patients of the public mental health system: as health and functioning improve, care could shift to teams of professionals (psychiatrists, psychologists etc) organised around the local referring GP. Ongoing care, symptom management and refinements of functional improvement could then take place in a non-stigmatising environment.

#### The Impact of the Rationalisation of Services on Service Provision

A significant problem with the restriction of treatment to a maximum of 10 sessions in a calendar year is one of **treatment effectiveness** . The purpose of this Better Access scheme was to have mental illness appropriately treated by specialists in the community without requiring that people (A) go untreated because of a lack of local service and (B) go untreated because then do not meet the criteria of acuity, severity or functional impairment required for access to the public mental health system. The empirical literature is very clear about the requirements for effective treatment: only panic attacks have any evidence about being treated in under 10 sessions. Everything else requires longer to treat effectively. When considering effective treatment, one must not be misled by initial changes in distress. Distress can fall quickly – in a matter of a handful of sessions – but ongoing vulnerability to relapse can remain unaddressed. For patients with mild "reactive" disorders this is unlikely to be a significant concern. However, for patients with moderate-severe mental illness, it is fundamentally important.

Relapse prevention is slower, longer and more subtle. It requires more meaningful change and yet the planned alteration to 'Better Access' will actively prevent people from engaging in this sort of work. The average number of sessions required to treat depression and meaningfully affect the relapse rate is in the range of 12-18 sessions. Similar numbers of sessions are required to treat generalised anxiety disorder, obsessive-compulsive disorder, social phobia and post-traumatic stress disorder. By restricting access you compromise the effectiveness of therapy.

One of the reasons cited by Minister Roxon was the lack of use of sessions and that most patients did not use more than eight sessions in a year. There are a number of problems with this

approach. The first problem is equating ceasing therapy with therapy effectiveness. People often seek help when they are distressed; they stop help seeking when they start to feel better. This is the common problem with antibiotics – people get them when they are feeling sick but stop them – often before the course is completed – leaving them exposed to the return of the illness. This is the perfect analogy for what we are seeing in these simple statistics. Effective treatment – treatment that reduces distress, leads to symptom reduction and relapse prevention – cannot be reliably achieved in such a brief number of sessions **for people with mental illness in the moderate-severe spectrum**. Effective treatment can be achieved in the range of sessions previously indicated. That the majority of people are not using a significant number of sessions does not mean that the sessions are not needed.

A further issue with cutting service is that it makes no logical sense. If people are not using a certain number of sessions then cutting them from the budget won't prevent government expenditure – the sessions aren't being used, the psychologists aren't claiming them, no one's paying for no one attending sessions that are not happening. How this can be thought of as "saving" is bizarre. For the few people that *are* using them, the issue is one of **need** – that people actually need this service, they are using the service appropriately and removing access to appropriate numbers of sessions for the group properly using them is a nonsense.

It is argued that the figures released by the Federal Government and analysed by the Australian Psychological Society show that individuals using the Better Access service often had a 'moderate' level of mental illness. I wish to make it clear to the members of the Senate committee what this might mean. Let us be perfectly clear that "moderate" depression is not a "bad day" but rather weeks-months marked by sadness, amotivation, suicidality and withdrawal from work and family (e.g., even mild illness is awful). Perhaps the members of the Senate subcommittee might like to consider what moderate sexual dysfunction (decreased libido, impaired sexual enjoyment and performance, resulted frustration and relationship problems) does to one's self esteem and one's relationship with an intimate partner? Moderate illness is not some sort of discrete problem that one simply put out of one's mind when we carry on that day to day tasks – by definition moderate illness is distressing, impairing and at the level that reaches criteria to be diagnosed as an illness. Unfortunately, the idea of a "mild or moderate" mental illness may make it sound similar to a cold – you can just shake it off. It is, of course, nothing of the sort. A cold does not leave you withdrawing from your friends, wanting to leave your family, feeling not quitting a job and considering killing yourself. This is exactly where mild or moderate depression can leave you – it is considered a mental illness for a reason and the reason is its broad, pervasive and unpleasant impact on self and the world in which you live.

The impact of restriction of service is that people with moderate levels of illness will not receive adequate treatment.

#### The Impact of Session Rationalisation on People with a Severe Mental Illness

The restrictions on access to service will also have a significant impact on individuals with **severe mental illness**. I would like to use to brief case examples to highlight this problem. Please note that within the case examples I have removed as much of the identifying information as I can without completely distorting the cases themselves and as a result all names, ages and dates have been removed.

Working in an outpatient clinic, I was referred a patient for assessment and treatment. The patient was a middle aged woman living with her parents. She had presented to her GP with a number of physical problems and investigations could not find any organic causes for these experience. The patient had a history of brief periods of treatment within the public mental health system over the last 25 years and have diagnoses had included social phobia and depression. The diagnosis of schizoaffective disorder (a severe form of mental illness) had been raised but not confirmed. This lady was unemployed and had been so for many years. She had begun but never completed a significant number of courses. Her physical problems prevented her from living independently and she was functionally reliant on her active but elderly parents.

I engaged the patient in a relatively complex assessment process, provided feedback on the assessment to the patient and the referring psychiatrist and to organise an ongoing treatment plan. What was evident through the assessment was that this woman has a severe mental illness in the form of a personality disorder and a long-standing major depressive illness. Effective treatment for this type of patient is long-term therapy. However, as she is not acutely suicidal or presenting with a major mental illness such as schizophrenia or bipolar disorder, she will not be accepted for service by the local area mental health's. Her illness is severe as it prevents her from working, having successful relationships and engaging with the community. She is reliant on her elderly parents. The functional impact of the illness is deep and pervasive and yet she cannot and will not be treated by the public system. Even were she accepted in the public system, I doubt that there are professionals with enough experience and time to manage a moderately long term therapeutic relationship that does not involve medication management. My experience of working in the public system leads me to believe that it is this sort of patient we would not have accepted. Shortening the already unrealistically small session availability impairs this woman's opportunity to access and use evidence-based effective therapies from highly skilled practitioners. She is going to remain a burden on society; the potentially effective treatments that exist are beyond her grasp.

The second case example is of a young man referred to me by his GP. He had recently been discharged from hospital after a brief psychotic episode. This young man has a long history of suffering from schizophrenia and is managed in the private system as he refused to be involved with the public system due to their experiences with it. This patient has a long-term girlfriend with whom he has children. When well, he holds down full-time employment and is involved in his local footy club. His treatment needs are a complex balance of the treatment of psychotic symptoms – which he experiences on a chronic level regardless of medication dosage – work on self-esteem, problem-solving and relapse prevention. Treatment also requires a balancing act with this young man's personality and his experiences of perceiving criticism from mental health professionals. Ten sessions a year is not going to address all the goals mentioned and do so in a way that balances the need to achieve goals with having an effective therapeutic relationship. The evidence base for effective treatment of psychotic symptoms demonstrates that it can require somewhere between 18 and 30 sessions. This is due to the complexity of the illness and the need to have a strong and well established therapeutic relationship. The restriction in access to service impairs the patient's ability to get what he needs in order to be who he wants to be – an engaged, active and vibrant member of this community. I would also ask the members of the Senate subcommittee to reflect upon the impact of a lack of service for his family – to his girlfriend and his children. What you think it does to them to see him bouncing in and out of hospital every year? What you think it does to his kids to know that their father is loving but also at times bloody scary and quite unpredictable?

These two examples demonstrate the nature of the challenge: both patients need long-term therapy. They need complex formulations that accurately capture their case history and provides a plan for ongoing treatment. They need to be engaged in a therapeutic relationship that can sustain the ups and downs of treatment. This cannot be done in 10 sessions. To cut back session availability will impair the provision of effective treatment to people with severe mental illness, many of whom cannot or do not receive effective public treatment.

### The Two-Tiered Medicare rebates

I would like to now address the issue of the two tiered nature of the Medicare rebate system for psychologists. There are two levels of rebate for (a) psychologists practising focused psychological strategies and (b) for clinical psychologists. There is a group of psychologists protesting against this ruling, arguing that clinical psychologists are no different to "generalist psychologists". I would urge the Senate committee to consider this argument as absurd and false and treat it with disdain that it deserves.

Clinical Psychology is recognised in Australia by the Australian Health Practitioners Registration Board as one of the nine specialisations in psychology. Clinical psychology is seen as a specialisation within psychology in the United Kingdom, America, Canada, and Europe. I would argue that it is unlikely that all of these countries have been misled and have misclassified this specialisation.

Clinical psychology stands alone (with Psychiatry) in regards to the length of training, standards of ongoing professional development, skills in assessment, diagnosis and treatment implementation that are an inherent part of training and ongoing practice. Clinical Psychology requires a minimum of eight years' training to obtain the specialist qualification. It is the only profession, apart from Psychiatry, whose postgraduate training is specifically in:

- (a) empirically-informed theories of personality and psychopathology;
- (b) Valid and reliable assessment of personality, psychopathology and cognitive performance;
- (c) Complex diagnosis, case formulation and treatment planning;
- (d) Evidence-based treatment implementation and evaluation;
- (e) Research method and practice.

Clinical Psychologists are uniquely trained to understand mental health and illness across lifespan development (i.e., from birth to old age), running the gamut of severity, complexity and co-morbidity. The treatment of individuals presenting with moderate- to-severe forms of mental illness is a unique specialised aspect of the training to practice Clinical psychology. The evidence in the empirical literature regarding effective treatment indicates that more than thirty sessions per annum are sometimes required. Given the demands and complexity of assessment and treatment, it is more accurate and honest to see Clinical Psychologists in the manner of Psychiatrists under Medicare: members of both professions independently diagnose and treat patients with moderate-to-severe illness within their professional practices. Instead of cuts to

session numbers, I would ask that they be extended; instead of seeing psychologists as adjunct treatment providers, they should be seen as primary treatment providers in mental health; Clinical Psychologists should be treated under Medicare as Psychiatrists.

The "generalist" argument is that the 'Better Access' figures do not demonstrate a meaningful difference between practitioners. This argument alone should be enough for you to dismiss this group as unreliable. The 'Better Access' scheme was not designed to test difference in therapist outcome. Its measures are not designed to measure differences in therapist outcome. It is not designed to gather highly detailed and accurate pictures of diagnosis. It would fail every reasonable measure of a scientific study or any standards of scientific rigour. That the generalist group is proposing a difference based on an ridiculous foundation is testament to their failure to understand basic science and to apply it in a practised manner to the field of mental health service provision.

Before all this gets lost in an angry, bitter debate I would ask you to consider the following: who would you prefer to see for heart surgery – a cardiac surgeon or a general practitioner? No one would say that you must see general practitioner or force you to only consult the cardiologist. No one would say that all cardiologists are in every way and on every example superior to all GPs when it came to understanding heart function. However, were it you, were it your partner, child or parent in a position of needing to seek specialist help, what would you say? Would you tell them that "all doctors have the same training and thus produce the same result"? Would you prefer to seek a specialist for a specialist problem? Clinical psychology is a specialisation recognised worldwide. Training and ongoing professional development standards in this country have, for this discipline, never been higher. To reduce the rebate would encourage nothing other than the lowest common denominator approach, fail to recognise the well tested and understood 'work value' in Clinical Psychology and demonstrate a failure of the federal administration to understand the realities of a complex issue such as professional difference in the field of mental health service provision.

I think the members of the committee for taking the time to consider my submission and will look forward to reading your decision process.

Yours sincerely

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Clinical Psychologist.