



Psychotherapy & Counselling
Federation of Australia

Response to KPMG's Evaluation of the Better Access Initiative [BAI]: A summative evaluation of policy and process - February 2009

Thank you for the opportunity to present this response on behalf of 37 Member Associations of the Psychotherapy and Counsellors Federation of Australia, representing 1533 Registered Clinical Psychotherapists and Counsellors in all Australian States and Territories and a further 1500 practitioners who are members of the Member Associations who are not in private practice or seeking registered practitioner status at this time..

On the 22nd April PACFA held a formal consultation with the Member Associations in Sydney to prepare a considered response to the questions provided by KPMG. There was general acceptance that practitioners without Medicare Access have been losing business, some to the point of having 20% of what they had previously. Many have had members cease practice, leaving a shortage of frontline experienced practitioners in specific forms of counselling, psychotherapy and hypnotherapy fields of practice. Members indicated that this has the effect of increasing waiting times for service from the remaining practitioners furthering client stress.

Clinical practitioners have found that there is a need for greater clarity around Health Policy. There seems to be a difference between the intention of the Better Access initiative and Government intentions as set out in the National Mental Health Policy 2008 in respect of priorities for access to mental disorder, mental illness and mental health service provision for a mental health system that:

- enables recovery
- prevents and detects mental illness early
- ensures that all Australians with a mental illness can access effective and appropriate treatment and community support to enable them to participate fully in the community.

It would be accurate to state that our members appreciate the access to therapy which the MBS rebates scheme gives some people, especially students, the disturbed and low income clients. Our members support its intention 100 percent, but seek redress of unintended consequences.

PACFA on behalf of its Member Associations submits the following responses to KPMG's Evaluation of the Better Access Initiative [BAI]: A summative evaluation of policy and process.

THEME ONE: SERVICE ACCESSIBILITY

To what extent has the Better Access Initiative provided access to mental health services for people with mental health disorders? Across all Australia? Across all age groups?

To what extent has the Better Access initiative provided access to affordable care?

To what extent has the Better Access Initiative provided equitable access to populations in need? (In particular people living in rural and remote areas, children and young people, older persons, Indigenous Australians, people from culturally and linguistically diverse backgrounds).

PACFA considers the Better Access initiative has been successful in creating greater awareness of mental health services by general practitioners and increased demand for mental health plans in accord with the intentions of the BAI. This has had the impact of shifting the focus towards access and effective and appropriate treatment of mental illness and, potentially, recovery where medical expertise is a requirement. It has not increased the access to mental health services that are directed towards the prevention and early detection of mental illness. It has enabled psychologists to concentrate more on private practice, placing a greater incentive on GPs to refer to psychologists and, to a lesser extent, social workers, instead of counsellors because of the MBS rebate for completing a mental health care plan. It has been less successful in ensuring equitable access to affordable care to all populations across the nation, including people living in rural and remote areas etc. Evidence from the published distribution of allied health professionals and data taken from the Australian Census shows that there is an intense focus of resources in the Capital Cities and in electorates that do not demonstrate low levels of social inclusion. There are stark differences in access to allied health services between urban and rural areas, as well as between non-capital city rural locations and remote communities, especially in respect of access by indigenous and other culturally diverse communities within each State and Territory. Details of distribution of Counsellors, Psychotherapists, Psychologists, Social Workers and Psychiatrists in relation to the number of General Practitioners by electorate are attached to this submission as Appendix One.

Figures from the Mental Health Council of Australia and the Australian Psychological Society indicate that the majority of services are found in capital cities on the east coast. It is contended that clients in need of BAI services who

live in regional, country, isolated, outer suburbs or in low socio-economic areas are being disadvantaged by BAI and how it is being delivered by service providers that have been accepted under the MBS system.

There is little access to services for those unable to pay gap payments due to the lack of bulk billing services, whilst there are counsellors and to a lesser extent psychotherapists in these areas who are able to close these gaps. It is unrealistic to believe current BAI providers are going to close these gaps because of their ability to demand high incomes in centres around major population bases.

While there is evidence of an increase in access to psychologists and social workers in more affluent areas, there has been no significant increase in services to areas with low levels of social inclusion. Once clients become aware of the gap payment, they find they are unable to maintain attendance at services for more than a short period. This indicates that access to BAI is limited even for those who first access it. With less than 30% of psychologists offering bulk billing services (APS find a psychologist page).

We have evidence from a number of sections of PACFA Member Associations that those of our members who do not have access to Medicare rebates have had to turn away clients who are unable to pay who are presenting with mental disorders. If they were able to access a psychotherapist or counsellor this could prevent the long term costs of mental illness. There are a wide range of emotional and social wellbeing community support services that are provided by counsellors and psychotherapists that are excluded under current BAI provisions..

A survey of over 300 Christian Counsellors across Australian found that only 31% had found no decline in their consulting hours, 29% a reduction less than 25% of hours, and 32% a reduction in excess of 25%. One in five of these practitioners are considering closing their practice as a result of the introduction of the BAI. This has to an extent been offset by the 38% engagement of the services of these Counsellors by clients who have been dissatisfied with services provided under the BAI.

Please note indicative comments received in the PACFA Consultation (details supplied and available on a confidential basis to the auditors if required):

Eg1.

I am a psychotherapist in private practice with a 4 year post training practice. Since the introduction of the Medicare rebate to psychologists there have been several patients of mine who have left seeking a cheaper option through the Medicare assisted Care Plans with psychologists. I am also

informed by some of my referring general practitioners that despite their referral of patients to me the patients state that they prefer to see a psychologist simply because they can receive financial assistance through Medicare.

Eg2.

My Doctor would far rather refer to myself than to the psychologists he knows, but he cannot unless they are sufficiently well-heeled given the availability of rebates. At our consulting rooms we have 15 practitioners. It is clear that psychologist referrals have risen, and psychotherapy referrals have matched this by their decline. Psychologists have increased the extent of their room bookings (roughly three fold since rebates came in). Two psychotherapists have ceased trading. Others are struggling.

Eg3.

Many of our members who are psychologists and social workers have reported that General Practitioners refer clients to them with little or no understanding of what the treatment of the severe personality disorders requires. Many tried to inform the referring GPs about this but with little success. It is our sense that while General Practitioners might be competent in referring those clients who are suffering from mild anxiety / phobias etc that are amenable to CBT, they are not educated in diagnosing or referring those clients with serious personality disorders. This group constitutes a large and under-managed population in general practice that come under the umbrella of so-called 'Heart-sink patients'. Our members are highly trained to treat this group.

Eg4

I do believe that I am underpaid for the health care that I provide to the community. I can not, on principle, pass on the costs of this situation to the client. So I am forced to undercharge for clients on welfare or poorly paid and yet some of these clients are from the most traumatised group in our community and require intensive and time consuming therapies. It is because of their psychological disorders that they are unable to function in the community.

Eg5

I have been in private practice for 15 years and my major source of referrals in the past has been through the medical profession probably accounting for 60% of my client base. Since the introduction of Medicare rebates to a select few registration bodies, e.g. the Australian Psychological Association (APA), my doctor referrals have now dwindled to zero as I cannot offer Medicare rebates. I am struggling to keep my practice operational.

Of significance in society today is the high rate of marital breakdown causing families to splinter and, to quote a speaker at a Family and Marital Therapy Conference at Queensland University, our society now contains thousands of "suitcase kids" (children constantly packing a suitcase to go to mum or dad for a few days at a time) which undermines the stability of those child development years and has the potential to cause psychological, emotional and behavioural problems. In addition, attempts to introduce a step-parent into the children's lives is fraught with problems which often causes yet another relationship breakdown, de-stabilising the children further and contributing to further adult problems of misery.

I am extremely disappointed that Therapists like myself, who have undertaken many years of study and who are well qualified to handle cases referred to in the last paragraph, are hindered by an unfair and unjust system and the general community are denied the opportunity to choose from a wide base of options as to which therapist will suit their needs the best. In my own case, I have studied family and marital therapy for some two years beyond my university education and collected certificates and diplomas in other areas which compliment my psychology degree, yet are not covered by Medicare. I am particularly concerned that I do specialise in an area that is in great demand, i.e. relationship counselling, yet many people who enquire of my services are restricted from following through with an appointment because they simply cannot afford to.

Eg6

My practice was significantly impacted by the introduction of the Medicare rebates. I used to get a significant number of referrals from GP's and Psychiatrists. All of these disappeared almost overnight. Within 6 - 12 months of the introduction, my practice had reduced by 40%-50% and while it has somewhat improved from the immediate impact, it has never climbed back to the way it was. The biggest issue I experience is not the rebates themselves – there are ways to deal with the dollar's issue. The biggest issue is the perception that I am not a professional practitioner (otherwise I'd be recognised by the system – right). To many potential clients, the perception is that if I am not in the Medicare system, while others are, then I must not be suitably qualified to assist them. They don't know or understand the various terms, psychologist, psychiatrist, counsellor, psychotherapist; so they rely on the recognition of the "system". They might ask, I might explain it satisfactorily, but nevertheless, those who are recognised must be "better".

Eg7

I had not imagined how difficult it was going to be as an unknown person starting from scratch. It took 18 months before a tiny trickle of clients began to reach me. Medicare rebate arrive shortly afterwards. My practice was

decimated in one blow. I could no long even vaguely support my family on my earnings. I had savings but they were going fast. I took a \$23 per hour job as a counsellor. This was quite a change from the \$200 per hour I had been used to in London.

Because I did not have a degree in psychology my 10 year plus training was not recognised. I had formally trained as a psychoanalytical psychotherapist. This was a basic 4 years academic training, 4 years supervised clinical work, and a total of 15 years of psychotherapy between twice and five times a week. There was never any doubt about my clinical competence just how much I should be paid or if I should be paid at all by Medicare, I got a new job in the public health service at \$28 in Drug Alcohol and Gambling. It was the only work I could get. As well as providing clinical services, supervision to clinical psychologists and teaching counsellors my rate of pay was less than half of what the Clinical Psychologists were paid. There was no option for me to go back into private practice as 9 out of 10 callers were asking for the rebate when they called for a private appointment.

In the end I was forced to go into health care management where I can earn a salary more commensurate with that of a Clinical Psychologist. I now earn the princely sum of \$49 per hour. Believe it or not I am grateful! Had I not been appointed to the managers post (Drug, Alcohol and Gambling Counselling Service at Hornsby Hospital) my family would have had no alternative than to move back to the UK. So much for a "fair go society."

What has distressed me is that psychologists whom I have trained and supervised in Sydney can earn more than treble of what I can earn via Medicare. There seems to be no justice! Medicare seems incapable of extending it's rebate scheme on the evaluation and competence of the individual therapist. I know their reasons why and I guess their arguments are reasonable enough but what it does is create a monopoly for psychologists and their very powerful union.

Eg8

I have been in full time private practice for 20 years and have always had a full and busy practice. Since the advent of Medicare rebates for psychologists, I am finding it increasingly difficult to have sufficient patients in my practice. In fact while I have many referrals sent to me or have heard of my name, I am often in the position of having to refer these patients on to less experienced therapists in order that the patient is able to claim the Medicare rebate. I could provide you with exact figures but I estimate I have to refer on three patients a week in this way.

Eg9

I applaud the Better Access initiative and believe it is a very positive step in addressing the toll that mental illness takes upon our country socially, economically and relationally. I strongly believe however that the delivery of services could be further improved by extending the scheme to include appropriately qualified counsellors and psychotherapists. In an effort to address what is a very critical problem facing our society the government has unfortunately created a scheme that is anti-competition as only a segment of the professional population can access it. In addition to this the scheme devalues the skills and experience of a large group of well qualified, skilled practitioners who could be of enormous benefit if indeed the primary goal is to provide better access to mental health services to the Australian public.

As a private practitioner I can very clearly say that I have experienced a drop off in client numbers since the Better Access scheme became available. I regularly get phone calls from people who ask if I can give the rebate and who ask for referrals to psychologists when I tell them I am unable to do so despite being able to do the work. I can also state with certainty that I am not alone in this as I have talked to several colleagues across the country that have the same issue.

I am a member of the national management committee of the Australian Association of Relationship Counsellors (AARC Inc.) and have a private practice in Queensland. I have B.A and B.A Hons in Psychology, an M.A in counselling and a PhD in Marital and Family Therapy. I have the necessary qualifications and clinical experience to work with people struggling with mental illness both individually and within a family or relationship context. I am not however able to give a Medicare rebate to my clients as I do not qualify for the Better Access initiative. I have looked at all the paperwork and talked to several people and have come to the conclusion that the only way I can qualify is to join the APS and become a registered psychologist.

Eg10

I feel unable to participate fully in my local health professional community because I am unable to accept referrals, from local GPs or agencies, of clients able to work only with a practitioner able to receive the Medicare subsidy. I Am unable to accept referrals from psychologist colleagues whose own practices cannot service the type or number of patient's referred by GPs or other agencies experience the frustration and marginalisation of the non-endorsed, vaguely suspect professional, irrespective of the fact that the ANZAP training is post-graduate.

THEME TWO: SERVICE APPROPRIATENESS

To what extent has the Better Access Initiative provided evidence-based mental health care to people with mental health disorders?

Currently providers must be registered with Medicare Australia to provide allied mental health consultation items (see qualification details below). Psychological service providers funded by the other Commonwealth or State programs are not eligible, for example Community Health Centre services, State government hospital outpatient clinics or Department of Veterans' Affairs services.

The provision of primary mental health care as a form of evidence based psychotherapeutic intervention can currently be offered by psychologists, clinical psychologists, social workers under a GP Mental Health Care Plan but qualified clinical psychotherapists and counsellors who meet the requirements for Registration with the Australian Register of Counsellors and Psychotherapists have been denied access to the provision of evidence-based mental health care to people with mental health disorders.

The Senate Inquiry recognised that Counsellors provide an underutilised workforce of qualified professionals but required the existence of an independent national credentialing system that could separate qualified from unqualified practitioners. The establishment of the Australian Register of Counsellors and Psychotherapists (ARCAP) in 2009 meets that requirement and removes this as grounds for denial of access to the Better Access Initiative by Registered Counsellors and Psychotherapists who have been recognised as National Mental Health Practitioners with equivalent qualifications and experience to qualified social workers. PACFA established a special section in its National Register that provides for peer review entry to the Mental Health Practitioner category in a manner that accords with the standards and evidence-based procedures that apply to members of the Australian Association of Social Workers (AASW).

It is submitted by Member Associations of Counsellors and Psychotherapists that the failure to include registered Counsellors and Psychotherapists as service providers under the BAI has meant the needs and appropriate expectations of mental health consumers who are not yet, or who have previously experienced mental illness have not been appropriately met on an equitable and accessible basis. To this extent the Better Access Initiative fails to promote the mental health and well-being of the Australian community nor, where possible, prevent the development of mental health problems and mental illness as required by the National Mental Health Policy 2008. There is no research evidence that establishes that qualified counsellors and psychotherapists are less effective in providing evidence-based mental health

care that does not require medical qualifications or the application of a medical treatment plan and therefore it only serves to undermine and depreciate both the service scope and workforce potential in primary mental health care.

John C. Norcross the 2009 President of the Society of Clinical Psychology (APA Division 12), Professor of Psychology and Distinguished University Fellow at the University of Scranton, a clinical psychologist in part-time practice, and editor of the *Journal of Clinical Psychology* states in relation to this tendency for splitting in the profession of psychotherapy and psychology :

“Rivalry among theoretical orientations has a long and undistinguished history in psychotherapy, dating back to Freud. In the infancy of the field, therapy systems, like battling siblings, competed for attention and affection in a “dogma eat dogma” environment... Clinicians traditionally operated from within their own particular theoretical frameworks, often to the point of being blind to alternative conceptualizations and potentially superior interventions... Mutual antipathy and exchange of puerile insults between adherents of rival orientations were very much the order of the day. ...all psychotherapeutic methods are elaborations and variations of age-old procedures of psychological healing. The features that distinguish psychotherapies from each other, however, receive special emphasis in the pluralistic, competitive American society. Since the prestige and financial security of psychotherapists hinge on their being able to show that their particular approach is more successful than that of their rivals, little glory has been traditionally accorded the identification of shared or common components.”

Norcross, J. C., & Newman, F. C. (2003) Psychotherapy integration: Setting the context. In J. C. Norcross & M. R. Goldfried (Eds.), Handbook of psychotherapy integration. New York: Oxford University Press. (Selected excerpts; p3, 7-10; 17-19; 26-28; 30-45)

It is submitted that the limitations on access to a third of the workforce of professional practitioners (See Appendix Two) offering counselling and psychotherapeutic mental health services does not provide for the required reduction in the impact of mental health problems (even if it could be shown to address urban , affluent incidents of mental illness) including in particular the effects of stigma associated with being labeled as having required a Mental Health Plan. The latest figures indicate that individuals in higher socioeconomic areas have greater service access.

Evidence-based research shows that long term psychoanalysis and psychoanalytic psychotherapy are effective. As mentioned above, this is the case for a broad range of psychological conditions and in particular patients with more severe mental dysfunction. The evidence base strongly suggests that

psychodynamic models are much more appropriate to this client population. Accordingly, the shorter term model of the BAI does not provide a setting or time frame for proper mental health care for this patient grouping. Our members regard this as a major and fundamental failing of the BAI. Whilst there is an evidence base for the identified treatment modalities in the BAI, there are significant questions about the comprehensiveness of this evidence (Hardy, Barkham, Shapiro & Reynolds 1995, King, 1998)..

Members of the Psychoanalysis and Psychoanalytic Psychotherapy Section of PACFA feel that it is necessary for government to draw on evidenced based research from a wider field than just CBT studies, e.g., European psychotherapy and psychoanalytical evidenced based research. (SEE FULL SUBMISSION AS ADDENDUM).

These evidence based research studies show that our members belong to a group of providers whose treatment outcomes are not only healthy for their patients but that re-admissions into hospital have decreased, as has lost work time. Both clinically and financially this form of treatment has been proven effective overseas and in Australia. The BAI, by not including longer term psychoanalytic based treatment, has likely compromised the efficacy and outcomes of the initiative and limited and possibly neglected the effectiveness of treatment of an important patient population within Australia.

As mentioned, recent studies show that psychoanalytic psychotherapy, both individual and group, and psychoanalysis are effective. These studies also show that patients continue to improve even after treatment has ended. Milrod et al (2000) demonstrated statistically significant and clinically meaningful improvements in panic, depression, anxiety, and functional impairment both at treatment termination and at follow-up six months after completion of psychodynamic psychotherapy. Leichsenring and Rabung's (2008) meta-analysis of the effectiveness of long-term psychodynamic psychotherapy showed it "was significantly superior to shorter-term" modalities and that "long-term psychodynamic psychotherapy yielded large and stable effect sizes in the treatment of patients with personality disorders, multiple mental disorders, and chronic mental disorders". Bateman and Fonagy (2001) reported that borderline patients who completed a program of long term psychodynamic psychotherapy not only maintained their substantial gains at the end of treatment but also showed a statistically significant continued improvement on outcome measures. A similar outcome, with a similar population, had previously been demonstrated by Meares and his colleagues in an Australian context (Meares, Stevenson & Comerford 1999). This long-term follow up of patients treated intensively using psychoanalytic psychotherapy not only revealed positive clinical outcomes, but also positive economic outcomes in terms of reduced hospitalisation and use of other services. (Stevenson & Meares 1999; Hall, Caleo, Stevenson & Meares

2001). Sandell and his colleagues in Sweden (Sandell R, Lazar A, Grant J, Carlsson J, Schubert J, & Falkenström F) looked at more than 400 people before, during and after subsidized psychoanalysis or long-term psychotherapy as part of the Stockholm Outcome of Psychoanalysis and Psychotherapy Project (STOPPP). They demonstrated that patients in psychoanalysis continued to improve after termination. This observation lends support to the notion that psychoanalytic treatments sets a process in motion that the patient continues after the formal termination, suggesting an advantage to extended, in-depth psychotherapy or psychoanalysis over short-term psychotherapy or medication.

The studies referred to above are simply a sampling of some of the current research. Members of the Psychoanalytic Section are currently engaged in a comprehensive review of the international evidence for the effectiveness of psychoanalysis and psychoanalytic psychotherapy and would like it made known to government that they would be pleased to present this to them on its completion.

THEME THREE: SERVICE EFFECTIVENESS

To what extent has the Better Access Initiative improved health outcomes to people with a mental health disorder?

Patients must currently be referred by a GP, psychiatrist or paediatrician after the preparation of a GP Mental Health Care Plan that has the potential to stigmatise the client and reduce their independent status as they must declare that they have had such a plan in seeking government and sensitive private employment. The detail provided in the patient's plan is designed to improve health outcomes offered by the providers of psychological services in providing the most appropriate care and should be provided on referral, but leaves clients who are not mentally ill, merely seeking counselling and psychotherapy, concerned that these details are accessible to government agencies and civil authorities.

PACFA holds the view that the BAI has: discouraged the use of counsellors as a professional group; has encouraged psychologists and social workers to practice in areas of greater population density to realise financial benefits; and has enabled psychologists and social workers to set up in private practice, further compromising access for traditionally marginalised populations.

PACFA considers that the current approach that focussed on mental illness rather than wider constructs of mental and social wellbeing, prevention and recovery support leads to the medicalisation of mental health, with an increased tendency to utilise pharmacotherapeutic interventions. This is reflected by both the inappropriate labelling of individuals with mental illness when they are seeking counselling services that relate to less severe forms of mental disorder but wish to receive financial reimbursement, as well as the over-servicing of affluent individuals in metropolitan areas.

PACFA Members have not been able to establish evidence of any significant drop in the prescription of anti-depressants or anti-anxiety drugs by GP's but medical treatment represents only a small fraction of the professional field of psychotherapeutic or counselling services of members. This in itself would indicate that current services are having little effect on achieving the objectives of the National Mental Health Plan 2008 and have not decreased expenditure in relation to the PBS but have substantially committed government financial resources to a medical model of intervention. It is submitted that those who need mental health services within BAI other than in respect of mental illness are not being provided with evidence based preventative mental health care and that access to recovery directed services may be focused on the treatment of diagnosed mental illness under the Mental Health Plans.

GPs are filling out Mental Health Care Plans, labelling more individuals with 'mental illness', and increasingly referring patients to psychologists. Psychologists are aware of the tendency for increased referral from GPs, and are moving to areas with higher population densities to realise the financial benefits. Counsellors on the other hand are well aware of the BAI and its disadvantages for them as a professional group. As for consumers and carers, PACFA Members are aware of individuals who are being unfairly disadvantaged (e.g. work, insurance etc.) by the inappropriate labelling with 'mental illness' for professionals to satisfy the requirements of the BAI and be eligible for financial reimbursement.

THEME FOUR : MENTAL HEALTH CARE SYSTEM

To what extent has the Better Access Initiative impacted on the supply and distribution of the psychologist, social worker and occupational therapist workforce?

How has the Better Access Initiative interacted with other related programs / initiatives including the Better Outcomes in Mental Health Program and the More Allied Health Services Program?

PACFA's interpretation of the current implementation of the BAI is that it is mainly targeted at mental illness, not prevention or recovery. Counsellors play an important role in prevention of 'mental illness' by providing interventions targeted at maintaining 'mental health'. PACFA considers that the design of the BAI has implications for mental health care, as it fails to recognise the importance of the contribution of counselling and psychotherapy to the prevention of mental illness and the encouragement of early recovery. The introduction of an initiative that discourages the utilisation of counsellors and psychotherapists and encourages labelling people with 'mental illness', inevitably increases the tendency to 'medicalise' mental health care, with consequential increased pharmacotherapy

THE BAI has had a negative impact on the provision of interdisciplinary mental health care for people with mental disorders. It has meant, effectively, that people with mental disorders are in many cases referred to practitioners who may not have the training required to treat them effectively, while those psychotherapists and psychoanalysts who are trained to deal with complex mental disorders, including psychosis, but who are not eligible to receive referrals under the BAI, are not being referred these patients.

This means that highly-trained practitioners in the mental health field are under-utilised in their area of expertise while those who may not be adequately trained in these areas are being referred patients with whom they have difficulty in dealing. This situation is inequitable but also creates an ethical question in relation to the Better Access Initiative.

The promise of free, short-term therapy attracts people who may receive little benefit from such treatment, people with problems that require longer term therapy. The expectation of improvement that is the consequence of entering into a therapeutic relationship is not met. Indeed, the consequences of the BAI in this instance could be damaging and produce, in the patient, a negative attitude to therapeutic work.

That there are BAI endorsed practitioners who are finding that their training is inadequate is evident when they seek clinical supervision from psychotherapists and psychoanalysts. In those situations it is clear that the treatment they are trained to offer and the therapeutic requirements of the patient do not coincide. This is a common outcome when patients with anxiety, depressive and personality disorders that require long-term treatment seek treatment from them.

The solution to this problem does not necessarily lie in further training for psychologists, social workers and occupational therapists because training in psychotherapy and psychoanalysis takes many years. Rather it is in broadening the modes of therapy offered under the BAI. It is arguable that the system as it is currently constituted *discourages* practitioners from pursuing adequate training (of the kind which our members have done) by implying that relatively simplistic approaches (eg CBT) are sufficient to treat all mental health problems.

**THEME FIVE: SKILLED, KNOWLEDGEABLE, INTEGRATED
WORKFORCE**

To what extent has the Better Access Initiative provided interdisciplinary primary mental health care for people with mental disorders? Are professionals aware of how to access appropriate mental health care training? Are professionals accessing appropriate education and training?

PACFA proposes that appropriately trained and skilled counsellors contribute not only to the mental health of individuals upon referral from GPs, but also the maintenance of mental health / prevention of mental illness prior to referral on to more qualified and appropriate mental health practitioners. The issue here is that without the ability to obtain a provider number and bill to MBS, the 'prevention' step is being skipped and more people are being potentially stigmatised as having mental illness.

Due to the discriminatory nature of the introduction of the BAI, counsellors and psychotherapists are acutely aware of the initiative but believe that the interdisciplinary primary health care and preventive orientation has been undermined by the current focus on psychologists, social workers.

It appears that Psychologists are being attracted away from other fields of engagement and undertaking clinical studies to become Clinical Psychologists by the financial benefits of working in affluent, metropolitan areas, further worsening access issues for those in regional / rural / remote areas. This has had the effect of encouraging training institutions and universities to consider dropping their counselling and psychotherapy courses in favour of the attractive field offered through the BAI. Counsellors and Psychotherapists have the appropriate skills and capabilities to maintain mental health and refer on when required (i.e. significant contribution to prevention) as Registered National Mental Health Practitioners

THEME SIX: ADDITIONAL FOCUS AREAS

What are the characteristics, including clinical characteristics, of consumers receiving Medicare rebateable Better Access mental health services? Are professionals, consumers and carers aware of the Better Access Initiative? Has the initiative impacted on the use of medications prescribed for the treatment of mental disorders, in particular, anti-depressants?

Has the introduction of the initiative changed how and where professionals practice? i.e. a movement to another location, change from public to private sector, or change in the mix of public and private sector work?

Are there any unintended consequences for stakeholders due to the introduction of the Better Access Initiative?

It appears from the comments of members that this initiative has impacted dramatically on the distribution of referrals. In short those members who are included in the system have received more referrals, while those who are excluded report a significant drop in referrals. Some respondents have indicated that their practices are severely depleted and their livelihoods threatened, despite many years of training and large sums of money invested in the process of training and establishing practices.

In promoting a 6 or 12 session treatment framework, the initiative appears to be inadvertently fostering the idea that all problems can and should be able to be effectively addressed within the framework of short-term therapy. This is patently not the case, but members of the public do not, and cannot be expected to understand this. There is a serious risk that consumers may attend ill-trained practitioners, who may begin a psychotherapy process with them, but terminate prematurely, leaving the patient traumatised, and damaged by the process.

Some members who are also Mental Health Practitioners have noticed that their psychoanalysis client numbers have declined. It has been suggested that “this decline ... can be attributed to the lack of Federal Government financial support of psychoanalytic practitioners in the form of rebates”. There is growing evidence that a broad range of psychological conditions which generate severe chronic distress require longer term psychotherapy (as opposed to briefer CBT interventions). The evidence strongly supports the appropriateness of psychodynamic approaches.

ADDENDUM:-

Submission from the Psychoanalysis and Psychoanalytic Psychotherapy Section of the Psychotherapy and Counselling Federation of Australia to KPMG Evaluation of the Better Access Initiative.

EXECUTIVE SUMMARY

Five professional associations representing over 450 psychoanalysts and psychoanalytic psychotherapists have cooperated to present this submission.

While generally supportive of the Better Access Initiative, our members are concerned that there are limitations in the current system which could be readily addressed, such that the effectiveness of the Initiative could be significantly enhanced.

Our members support enhancements to the system to further support under-serviced and financially constrained patients, such as incentives for appropriately trained and experienced psychotherapists to offer services in regional areas, or to specific target populations.

We are concerned that the Initiative may underestimate the severity of the mental health problems for which treatment is being sought. Our members commonly receive referrals for multiple or chronic mental disorders, personality disorders, psychotic disorders and long term abuse/trauma cases. Such problems are not well served by the brief, structured therapeutic modalities which the Initiative endorses. Indeed, there is evidence that such interventions may be harmful.

Concern has been expressed that treatment modalities currently supported in the Better Access Initiative are limited. The submission presents arguments and evidence-based research to support the extension of treatment modalities to include psychoanalysis and long-term psychoanalytic psychotherapy for treatment of severe psychological disorders.

There appear to be inequities in the recognition of Mental Health Practitioners. On one hand our members report anecdotal evidence of under-trained and inexperienced practitioners offering services beyond their expertise, and with damaging results. On the other hand, our members represent some of the most highly trained psychotherapists in Australia, and yet there is inequity in the system such that, while most of our members are

recognised as Mental Health Practitioners, some are not. This inequity means that some highly trained and experienced practitioners are being effectively under-utilised.

In the interests of conciseness, we have kept this submission brief. We request an opportunity to meet with the Evaluation team to provide more detailed input.

Australian Association of Group Psychotherapists, Australian Centre for Psychoanalysis, Australian and New Zealand Society of Jungian Analysts, Australian Psychoanalytic Society, Psychoanalytic Psychotherapy Association of Australasia.

Submission from the Psychoanalysis and Psychoanalytic Psychotherapy Section of the Psychotherapy and Counselling Federation of Australia to KPMG Evaluation of the Better Access Initiative.

PREAMBLE. The Psychoanalysis and Psychoanalytic Section of PACFA consists of five associations: the Australian Association of Group Psychotherapists the Australian Centre for Psychoanalysis, the Australian and New Zealand Society of Jungian Analysts, the Australian Psychoanalytic Society, and the Psychoanalytic Psychotherapy Association of Australasia. Our member associations represent over 450 highly trained psychoanalysts and psychoanalytic psychotherapists. The majority of members of our member associations come from backgrounds such as Psychology, Psychiatry, Medicine and Social Work, and as such are eligible for registration as Mental Health providers. However there are within our ranks some highly trained and experienced practitioners who came to their psychoanalytic training via pathways which make them currently ineligible for registration as Mental Health practitioners. While these practitioners may not be recognised under the Better Access initiative, their training and expertise is recognised within our member associations, and within the Psychoanalytic Section as being equivalent in all respects to those members from Psychology, Medicine or Social Work backgrounds. The reason for this is that the training required for membership of our member associations is in itself significant. The *minimum* training requirements which member associations must have to be eligible for membership of the Psychoanalytic Section are as follows:

1. A tertiary degree and some relevant clinical experience as a prerequisite to training
2. Participation in a comprehensive seminar programme on psychoanalytic theory and practice of at least three years' duration, involving at least 250 hours of seminar involvement.
3. Weekly clinical supervision of at least two clinical cases of psychoanalysis or psychoanalytic psychotherapy and/or group psychotherapy seen a minimum of twice per week, one case for at least 24 months, and one for at least 12 months.
4. Personal psychoanalysis or psychoanalytic psychotherapy and/or group psychotherapy, at least twice weekly, with an approved psychoanalyst or psychoanalytic psychotherapist for the duration of training.
5. It is expected that there will be substantial concurrence of the three aspects of training – Psychoanalysis/Psychotherapy/Group Psychotherapy; Supervised Clinical Practice; Theoretical and Clinical Seminars.

In addition to these initial training and entry requirements, members of our associations are required to be engaged in substantial ongoing professional development and clinical supervision. It should be noted that these are the minimum training standards which member associations of the Psychoanalytic Section subscribe to, and that several of our associations, and many of the members of these associations have training which far exceeds these minimum standards.

We will address the terms of reference of the Evaluation, as published:

Service accessibility

To what extent has the Better Access Initiative provided access to mental health services for people with mental health disorders? Across all Australia? Across all age groups?

To what extent has the Better Access Initiative provided access to affordable care?

To what extent has the Better Access Initiative provided equitable access to populations in need? (in particular people living in rural and remote areas, children and young people, older persons, Indigenous Australians, people from culturally and linguistically diverse backgrounds)

Members of our Associations in general are very supportive of the stated aims of the Better Access Initiative (BAI) – to provide better access to treatment services for high need and under-serviced populations. The National Mental Health Policy 2008, (released March 2009), has provided statistical evidence for a better than expected outcome from this initiative. However, we believe there remains a problem for equitable BAI access across all populations requiring psychological services, which continues the ongoing problem for many years under Medicare services supplied by psychiatrists. Practitioners continue for the most part to be located in urban areas, and there is no incentive in the system for re-location to rural and remote areas, and to Indigenous Australians or other culturally diverse backgrounds.

In addition to current patients who have taken up the limited benefits permitted through BAI, most of our members have also been referred patients who might otherwise not have sought services. These include those with serious mental illnesses and on unemployment or disability pensions, or low incomes, who would be otherwise unable to afford the cost of psychotherapy. This however has complications for our practitioners, as the time-limited nature of the rebates means that long-term therapy, which is so often indicated for this population, is cut off prematurely.

Service appropriateness & Service effectiveness

To what extent has the Better Access Initiative provided evidence-based mental health care to people with mental health disorders?

To what extent has the Better Access Initiative provided services that match client needs and expectations?

To what extent has the Better Access Initiative improved health outcomes for people with a mental health disorder?

Service appropriateness and effectiveness are very complex questions. The BAI has been predicated on the superiority of a restricted range of treatment modalities (CBT, Interpersonal Therapy, and Narrative Therapy with indigenous populations). Our members regard an expanded range of modalities as being more advantageous for inclusiveness purposes and to meet all the target groups. Many of our members report seeing patients who have tried brief, structured interventions such as CBT and found them to be of limited effectiveness. This is not to suggest that CBT and other approaches are not helpful, but that rather that their usefulness is limited to certain patient populations.

This is particularly the case for the more serious disorders, for example, multiple or chronic mental disorders, "personality disorders" or long term abuse/trauma cases. The National Mental Health Policy 2008 recognizes this need to have a broad range of treatment modalities with its statement that: *"Central to the population health framework is a range of high quality, effective interventions that target those at different levels of risk or with different levels of need. The interventions should be comprehensive, ranging from prevention and early intervention through treatment to continuing care and prevention of relapse"* (p.10).

Our members draw on many models of mental dysfunction. As a result the patient is not fitted into one model but rather is fitted into a formulation and treatment plan based on the requirement of the individual. Thus our members strongly support diversity in service providers to reflect the diversity in clients' needs. These needs are not necessarily obvious to the patient in treatment but must be crucially kept in mind by the treating clinician. Clinicians (both treating and referring) need to have the training and experience to know the complex psychological treatment needs of their patients.

Evidenced Based Research for Longer Term Psychoanalysis and Psychoanalytic Psychotherapy and access to mental health services

Evidence-based research shows that long term psychoanalysis and psychoanalytic psychotherapy are effective. As mentioned above, this is the case for a broad range of psychological conditions and in particular patients

with more severe mental dysfunction. The evidence base strongly suggests that psychodynamic models are much more appropriate to this client population. Accordingly, the shorter term model of the BAI does not provide a setting or time frame for proper mental health care for this patient grouping. Our members regard this as a major and fundamental failing of the BAI. Whilst there is an evidence base for the identified treatment modalities in the BAI, there are significant questions about the comprehensiveness of this evidence (Hardy, Barkham, Shapiro & Reynolds 1995, King, 1998). At the same time, there is a significant, and growing body of evidence in support of the effectiveness of psychoanalysis and psychoanalytic psychotherapy.

Our members feel that it is necessary for government to draw on evidenced based research from a wider field than just CBT studies, e.g., European psychotherapy and psychoanalytical evidenced based research. These evidence based research studies show that our members belong to a group of providers whose treatment outcomes are not only healthy for their patients but that re-admissions into hospital have decreased, as has lost work time. Both clinically and financially this form of treatment has been proved effective overseas and in Australia. The BAI, by not including longer term psychoanalytic based treatment, has likely compromised the efficacy and outcomes of the initiative and limited and possibly neglected the effectiveness of treatment of an important patient population within Australia.

As mentioned, recent studies show that psychoanalytic psychotherapy, both individual and group, and psychoanalysis are effective. These studies also show that patients continue to improve even after treatment has ended. Milrod et al (2000) demonstrated statistically significant and clinically meaningful improvements in panic, depression, anxiety, and functional impairment both at treatment termination and at follow-up six months after completion of psychodynamic psychotherapy. Leichsenring and Rabung's (2008) meta-analysis of the effectiveness of long-term psychodynamic psychotherapy showed it "was significantly superior to shorter-term" modalities and that "long-term psychodynamic psychotherapy yielded large and stable effect sizes in the treatment of patients with personality disorders, multiple mental disorders, and chronic mental disorders". Bateman and Fonagy (2001) reported that borderline patients who completed a program of long term psychodynamic psychotherapy not only maintained their substantial gains at the end of treatment but also showed a statistically significant continued improvement on outcome measures. A similar outcome, with a similar population, had previously been demonstrated by Meares and his colleagues in an Australian context (Meares, Stevenson & Comerford 1999). This long-term follow up of patients treated intensively using psychoanalytic psychotherapy not only revealed positive clinical outcomes, but also positive economic outcomes in terms of reduced hospitalisation and

use of other services. (Stevenson & Meares 1999; Hall, Caleo, Stevenson & Meares 2001). Sandell and his colleagues in Sweden (Sandell R, Lazar A, Grant J, Carlsson J, Schubert J, & Falkenström F) looked at more than 400 people before, during and after subsidized psychoanalysis or long-term psychotherapy as part of the Stockholm Outcome of Psychoanalysis and Psychotherapy Project (STOPPP). They demonstrated that patients in psychoanalysis continued to improve after termination. This observation lends support to the notion that psychoanalytic treatments sets a process in motion that the patient continues after the formal termination, suggesting an advantage to extended, in-depth psychotherapy or psychoanalysis over short-term psychotherapy or medication.

The studies referred to above are simply a sampling of some of the current research. Members of the Psychoanalytic Section are currently engaged in a comprehensive review of the international evidence for the effectiveness of psychoanalysis and psychoanalytic psychotherapy and would like it know to government that they be pleased to present this to them on its completion.

Mental health care system

To what extent has the Better Access Initiative impacted on the supply and distribution of the psychologist, social worker and occupational therapist workforce?

Has the introduction of the initiative changed how and where professionals practice? (e.g. movement to another location, change from public to private sector, or change in the mix of public and private sector work)

Comments from our members suggest that to date the initiative has had little impact on distribution of the workforce to previously under-served geographical areas. However these same commentators indicate that the initiative has had a significant impact on the supply of some professional groups in that it has encouraged a large number of practitioners to move from public to private practice (in urban areas). Some of these are less trained and ill-equipped to deal with the target patient group of BAI.

Whilst there are highly trained professionals included in the BAI, anecdotal evidence indicates that this has been a mixed blessing. Many of our Section members have heard comments from patients who have unsuccessfully already seen other practitioners, suggesting that the level of training, skill and experience in some practitioners who currently receive rebates within this initiative is less than ideal.

We are concerned that the BAI system as it currently functions may engender a false sense of security in the public by implying that those

professional who have access to rebates possess the training and experience to treat serious mental health disturbances, when this is not necessarily the case. It is important to consider whether particular professionals have adequate training, experience and supervision to provide the appropriate level of care for these patients. Practitioners in our member associations not only possess a higher level of theoretical and clinical training, but have also been required to undergo substantial personal psychoanalysis or psychotherapy which we consider to be essential in equipping them to deal with these serious mental disorders. We consider this to be a serious ethical, as well as a pragmatic concern.

Skilled, knowledgeable, integrated workforce

To what extent has the Better Access Initiative provided interdisciplinary primary mental health care for people with mental disorders?

Are professionals aware of how to access appropriate primary mental health care training? Are professionals accessing appropriate education and training?

The Better Access Initiative has had a negative impact on the provision of interdisciplinary mental health care for people with mental disorders. It has meant, effectively, that people with mental disorders are in many cases referred to practitioners who may not have the training required to treat them effectively, while those psychotherapists and psychoanalysts who are trained to deal with complex mental disorders, including psychosis, but who are not eligible to receive referrals under the Better Access Initiative, are not being referred these patients. This means that highly-trained practitioners in the mental health field are under-utilised in their area of expertise while those who may not be adequately trained in these areas are being referred patients with whom they have difficulty in dealing. This situation is inequitable but also creates an ethical question in relation to the Better Access Initiative. The promise of free, short-term therapy attracts people who may receive little benefit from such treatment, people with problems that require longer term therapy. The expectation of improvement that is the consequence of entering into a therapeutic relationship is not met. Indeed, the consequences of the Better Access Initiative in this instance could be damaging and produce, in the patient, a negative attitude to therapeutic work.

That there are BAI endorsed practitioners who are finding that their training is inadequate is evident when they seek clinical supervision from psychotherapists and psychoanalysts. In those situations it is clear that the treatment they are trained to offer and the therapeutic requirements of the patient do not coincide. This is a common outcome when patients with

anxiety, depressive and personality disorders that require long-term treatment seek treatment from them. The solution to this problem does not necessarily lie in further training for psychologists, social workers and occupational therapists because training in psychotherapy and psychoanalysis takes many years. Rather it is in broadening the modes of therapy offered under the Better Access Initiative. It is arguable that the system as it is currently constituted *discourages* practitioners from pursuing adequate training (of the kind which our members have done) by implying that relatively simplistic approaches (eg CBT) are sufficient to treat all mental health problems.

Additional focus areas

Are there any unintended consequences for stakeholders due to the introduction of the Better Access Initiative?

It appears from the comments of members that this initiative has impacted dramatically on the distribution of referrals. In short those members who are included in the system have received more referrals, while those who are excluded report a significant drop in referrals. Some respondents have indicated that their practices are severely depleted and their livelihoods threatened, despite many years of training and large sums of money invested in the process of training and establishing practices.

In promoting a 6 or 12 session treatment framework, the initiative appears to be inadvertently fostering the idea that all problems can and should be able to be effectively addressed within the framework of short-term therapy. This is patently not the case, but members of the public do not, and cannot be expected to understand this. There is a serious risk that consumers may attend ill-trained practitioners, who may begin a psychotherapy process with them, but terminate prematurely, leaving the patient traumatised, and damaged by the process. Some members who are also Mental Health Practitioners have noticed that their psychoanalytical client numbers have declined. It has been suggested that “this decline ... can be attributed to the lack of Federal Government financial support of psychoanalytic practitioners in the form of rebates”. There is growing evidence that a broad range of psychological conditions which generate severe chronic distress require longer term psychotherapy (as opposed to briefer CBT interventions). The evidence strongly supports the appropriateness of psychodynamic approaches.

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