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Dear Sir / Madam,

Re: Senate enquiry into Medicare *Better Access to Mental Health Care*

I am writing to express my concerns regarding the proposed changes to Medicare rebates for therapy by Clinical Psychologists under the *Better Access* initiative, as follows.

I am a Clinical Psychologist with almost 10 years of postgraduate experience currently working in both Community Mental Health and Private Practice settings. I am a current member of the Australian Psychological Society (APS) and College of Clinical Psychologists (CCLIN). Note that my affiliation with both the APS and CCLIN pre-dates my involvement in private sector psychology service provision by several years.

1. Concerns regarding the proposal to reduce the number of Medicare rebates available to consumers seeking psychological therapy from 12 annually (up to 18 in "exceptional circumstances") down to maximum of 10 annually

The recent evaluation of the *Better Access* initiative demonstrated that the initiative was meeting it's target by increasing access to evidence-based psychological therapy for the Australian public. As expected, the majority of consumers were demonstrating mild-to-moderate symptom severity and were being discharged at (and in many cases *before*) the 12th session. Only a very small percentage demonstrated "exceptional circumstances" and progressed to greater than 12 sessions. *The significance of this finding should not be understated* – the preponderance of research trials demonstrate that the average number of sessions for evidence-based treatment of uncomplicated, Axis 1 disorders of mild-to-moderate severity (eg. CBT) is between 12 and 20 sessions.

What the evaluation failed to explore was *nature of exceptional circumstances necessitating greater than 12 appointments.* My own experience suggests that the following are common reasons for seeking additional treatment under "exceptional circumstances":

- Adverse events such as medical illness, life crises (eg. relationship breakdown, redundancy), relapse or exacerbation of psychiatric symptoms occur during the course of treatment. These occurrences are unforeseeable by the consumer, psychologist or referring doctor and can mean that discharge at the 12th appointment is clinically inappropriate;
- Additional attention to relapse prevention is clinically indicated;
- The consumer has a mental health diagnosis generally associated with a slightly longer course of treatment (eg. recurrent Major Depressive Disorder, Posttraumatic Stress Disorder, Obsessive Compulsive Disorder); and/or
- The consumer had more complex mental health care needs than were apparent to the referring doctor (e.g. comorbid undiagnosed substance abuse or personality disorder).

Providing no flexibility to extend the course of Medicare-funded treatment could adversely affect clinical outcomes for the consumer and/or unfairly shift the financial burden of care to either the consumer or treating psychologist.

2. Concerns regarding the proposal to eliminate the two-tiered Medicare rebate system for Psychologists

The recent evaluation of the *Better Access* initiative failed to demonstrate a significant difference in the outcome of services provided by specialist Clinical Psychologists when compared to 'generalist' psychologists (ie. those not deemed eligible for the higher level of rebate). However it is not reasonable to conclude on the basis of this application that there are "no grounds" for the two-tiered system.

There is a body of scientific literature supporting that novice and experienced therapists do not perform equally as providers of psychological therapy. It is also universally accepted that higher levels of training and greater participation in ongoing professional development (in psychology and in other professions) are to be encouraged as a means of maintaining and improving practice effectiveness. These principles are evident in the recent evolution of Australian standards for the training and registration of psychologists, as well as international standards.

The changes in Australian and International standards go far beyond the scope and history of the *Better Access* initiative and are now enshrined in current registration and ongoing professional development requirements for psychologists (AHPRA). The recent *Better Access* evaluation lacks sufficient scientific rigor to draw meaningful conclusions regarding the relative efficacy of services provided by the different psychologist 'tiers' (eg. sampling methods were not controlled, objective and standardized assessment of pre- and post-treatment symptoms was not used etc). The *Better Access* evaluation should not be used to dismiss the value of pursuing higher qualifications and standards of ongoing professional development. Participation in these activities serves an important function including public protection and ensuring high standards of psychological service delivery.

I note that the evaluation also failed to consider whether Clinical Psychologists were actually charging higher fees for service than their non-Clinical peers on the lower Medicare 'tier'. Shifting to a single tier and lower level of Medicare rebate will be a financial disincentive for consumers to access psychological treatment.

It cannot be assumed that consumers who require more than 10 sessions of therapy or who are unable to make significant financial co-contribution to treatment under *Better Access* are able to access a psychologist in the public mental health system. There is considerable inconsistency between states in the availability of psychological therapy in the public system. Recent reports by both the Social Inclusion Unit and Psychologists Association of South Australia have highlighted the poor availability and growing problems with respect to recruitment and retention of psychologists in the South Australian public system. Indeed, South Australia is falling behind most other states in the availability of public sector psychologists.

3. Summary and closing comments

There is extensive research demonstrating that evidence-based psychological interventions are cost-effective to health care systems, but that cost savings are realized in the medium and longer term. Reducing the number of sessions for which consumers can access a Medicare rebate will adversely effect clinical outcomes for consumers, erode improvements

in access to mental health care services achieved by *Better Access* to date, and reduce the social and economic benefits of the program for all Australians.

The scope and design of the *Better Access* evaluation has not been sufficient to conclude that the two-tiered system of Medicare rebates is invalid or ineffective. Shifting to a single tier of Medicare rebate will erode the quality of psychological service provision by discouraging psychologists to pursue clinical excellence through further education and professional development. Moving to a single-tiered model is likely to financially disadvantage consumers and reduce their access to mental health care services. Many consumers being treated under the *Better Access* initiative cannot access equivalent psychological services in the public sector.

I strongly urge the Senate to reconsider the proposed changes to *Better Access* in light of the above.

Yours Sincerely,

Amanda Burlock
Clinical Psychologist