Submission

(a) the Government's 2011-12 Budget changes relating to mental health;

The Government's announcement regarding mental health were disingenuous disguising cost shifting within the total Mental Health Budget away from evidence based care for those needing assistance to administrative expenditure and forms of client care for which there is little evidence for adequate access or improved recovery (refer APS Information at Appendix A.)

It is mystifying why the government has ignored the evidence provided by it s own report that is the *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative, Summative Evaluation, FINAL REPORT, 22 February 2011 Executive summary*

… There is good evidence that Better Access has improved access to mental health care for people with common mental disorders. Uptake of Better Access services has been high in absolute terms, even among relatively disadvantaged groups in the community.

… Better Access is not just catering to people who were already in receipt of care and/or who have relatively mild symptoms; it is reaching significant numbers of people who have not previously accessed mental health care; and it is providing treatment for people who have severe symptoms and debilitating levels of distress.

… Consumers are generally positive about Better Access as a model of service delivery and they appreciate the clinical care they have received. They are also reporting positive outcomes as assessed by reductions on standardised measures of psychological distress, depression, anxiety and stress. In the main, these outcomes are related to clinical and treatment factors rather than socio-demographic characteristics.

… Preliminary analysis of outcome and cost data for consumers seen by psychologists through Better Access suggests that the initiative is providing good value for money; equivalent data were not available for consumers seen by other provider groups.

… These achievements do not seem to be occurring at the expense of other parts of the mental health system. The numbers of allied health professionals in public mental health services have continued to rise, despite the attraction of working as private practitioners in the primary mental health care sector. In fact, Better Access may have had a positive effect on the way in which the Australian mental health workforce operates, with some indications that providers are engaging in more collaborative care.

… These achievements should not be under-estimated. Good mental health is important to the capacity of individuals to lead a fulfilling life (e.g., by studying, working, pursing leisure interests, making housing choices, having meaningful relationships with family and friends, and participating in social and community activities). This major mental health reform seems to have improved access to and outcomes from primary mental health care for people with moderate to severe common mental disorders.

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

(i) the rationalisation of general practitioner (GP) mental health services,

(ii) the rationalisation of allied health treatment sessions

(iii) the impact of changes to the Medicare rebates and the two-tiered rebate structure for clinical assessment and preparation of a care plan by GPs,

(iv) the impact of changes to the number of allied mental health treatment services for patients with mild or moderate mental illness under the Medicare Benefits Schedule;

GPs are the gate keepers to the health system. A mental health diagnosis requires at least one long consultation of a 60- 90 mins duration with subsequent write up and possible follow up, setting of a plan and follow up. How can funds for this work be cut with out a loss of service delivery.

On what clinical evidence where these changes made? How will the foreshadowed changes ensure treatment outcome are delivered to those who are most in need? How will the proposed changes ensure that there are evidence based changes to the mental health status of those accessing those services?
As can be seen in tables provided below – low to moderate mental illness is the minority of treatment being delivered in the current scheme.

The propaganda being spread about "middle class welfare" and "the worried well" is not borne out by the services being delivered in the current scheme.

If changes are to be made then proper clinical auditing should confirm practices of GPs in allocation in of 6 12 and 18 week treatment cycles to those who are in clinical need. Pre Midterm and post measures of Psychological treatment and appropriate survey of patients and their outcomes should be made in conjunction with Clinical audit of GP decision making.

(b) the impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program;

Submissions by the APS and the evidence provided in the above tables show that moderate to very high mental illness is being treated effectively in people in need. Regional delivery needs improvement but this is a workforce and capacity building issue. The cutting of rebates and service numbers does nothing to assist in the building of service delivery in regional Australia.

(c) services available for people with severe mental illness and the coordination of those services;

There are many mental health issues which have a high impact on the community and the mental health system.

Better information is required on the epidemiological impact of these issues so as to best allocate funding and interventions. Some health issues are given priority by the media and by well organised lobby groups.

In practice settings, Drug and Alcohol and Borderline Personality Disorders have as high an impact as Psychosis and Bipolar disorder.
Suicide is however often occurring in the absence of any mental health disorder.

Service delivery in all these areas are lacking disjointed and where they exist under resourced.

(e) mental health workforce issues, including:

(i) the two-tiered Medicare rebate system for psychologists,

(ii) workforce qualifications and training of psychologists, and

(iii) workforce shortages;

The evidence gathered by the evaluation of 22 February provides interesting evidence about the effectiveness of delivery by both Clinical and registered psychologists.

Table 12 and table 13 show that all psychologists in the Medicare system are treating similar patients of similar severity and obtaining similarly effective outcomes.

Much is made of the qualifications of Clinical Psychologists in the bulk of submissions by Clinical Psychologists. However, ongoing (and expensive) professional development undertaken by Registered psychologists and its application to practice must be taken into account when considering the current competence of all professionals in achieving the outcomes outlined in the Tables below. The level of income through gap payments is also unclear.

The current system also fails to adequately recognise the professional expertise of the other Psychological Colleges eg, Health, Counselling , Neuropsychology, Educational etc in providing complex treatment of psychological presentations such multiple co morbidities, drug and alchohol and group delivery of treatments.

The question regarding tiered rebates should be established by objective assessment of current professional competence, client group and outcomes including clinically significant and lasting change.

Having been placed with both registered and clinical psychologists in a busy practice in regional area – it was apparent that they respected their professional skills as being of equal value and that the question of two tiered fee structures was a drawback to clients and undermined practice viability.

The Tiered structure of rebates needs to be outcomes and competency based.

Table 12: Clinical profiles of consumers who participated in Component A[1]

		Consumers recruited by clinical psychologists (n=289)[2]		Consumers recruited by registered psychologists (n=317)[2]		Consumers recruited by GPs (n=277)[2,3]	
		Freq	%	Freq	%	Freq	%
Diagnosis	Depression and anxiety[4]	99	34%	121	38%	113	41%
	Depression without anxiety[4]	105	36%	117	37%	102	37%
	Anxiety without depression[4]	66	23%	60	19%	38	14%
	Other[5]	19	7%	19	6%	24	9%
Pre-treatment K-10 score	10-15 (Low psychological distress)	13	5%	8	3%	8	3%
	16-21 (Moderate psychological distress)	37	13%	43	14%	26	10%
	22-29 (High psychological distress)	103	36%	93	31%	81	30%
	≥30 (Very high psychological distress)	133	47%	159	53%	158	58%

1. Received care through Better Access between 1 Oct 2009 and 31 Oct 2010.
2. Consumers recruited by GPs may have received treatment from the GP in isolation or may have been referred to an allied health professional for further care.
3. Cells do not always sum to the total n due to some missing data.
4. With or without alcohol and drug use disorders, psychotic disorders, and/or unexplained somatic disorders.
5. Alcohol and drug use disorders, psychotic disorders, unexplained somatic disorders, and/or unknown or missing diagnoses.

Table 13: Outcome data for consumers who participated in Component A and had "matched pairs" of pre- and post-treatment scores on standardised measures[1]

		Pre-treatment mean (s.d.)	Post-treatment mean (s.d.)	Mean difference (s.d.)	P-value
Consumers recruited by clinical psychologists	**K-10[4] (n=193)**	28.63 (7.57)	19.09 (6.96)	9.53 (7.84)	0.000
	DASS_Depression[5] (n=205)	21.02 (11.00)	9.66 (9.63)	11.37 (10.92)	0.000
	DASS_Anxiety[6] (n=205)	14.75 (9.44)	7.58 (7.32)	7.17 (8.73)	0.000
	DASS_Stress[7] (n=205)	22.85 (8.58)	12.93 (8.48)	9.93 (9.50)	0.000
Consumers recruited by registered psychologists	**K-10[4] (n=192)**	29.44 (7.33)	18.86 (7.13)	10.58 (8.83)	0.000
	DASS_Depression[5] (n=204)	20.41 (10.58)	8.96 (8.99)	11.46 (11.43)	0.000
	DASS_Anxiety[6] (n=204)	15.34 (9.59)	6.55 (7.01)	8.78 (10.09)	0.000
	DASS_Stress[7] (n=204)	23.91 (9.41)	12.22 (9.28)	11.69 (11.01)	0.000
Consumers recruited by GPs[2,3]	**K-10[4] (n=177)**	30.89 (7.94)	22.88 (8.54)	8.01 (8.72)	0.000

1. Received care through Better Access between 1 Oct 2009 and 31 Oct 2010.
2. Consumers recruited by GPs may have received treatment from the GP in isolation or may have been referred to an allied health professional for further care.
3. The DASS-21 was only collected for consumers recruited by clinical and registered psychologists, and not by consumers recruited by GPs.
4. Standard cut-off scores for levels of psychological distress are as follows: 10-15 (Low); 16-21 (Moderate); 22-29 (High); ≥30 (Very high)
5. Recommended cut-off scores for conventional severity labels are as follows: 0-9 (Normal); 10-13 (Mild); 14-20 (Moderate); 21-27 (Severe); ≥28 (Extremely severe)
6. Recommended cut-off scores for conventional severity levels are as follows: 0-7 (Normal); 8-9 (Mild); 10-14 (Moderate); 15-19 (Severe); ≥20 (Extremely severe)
7. Recommended cut-off scores for conventional severity levels are as follows: 0-14 (Normal); 15-18 (Mild); 19-25 (Moderate); 26-33 (Severe); ≥34 (Extremely severe)

However in the absence of Health Workforce Australia and the Australian Health Professions Registration Authority delegating this role to University Masters programs this is a problematic suggestion. The Masters programs are concerned with academic administration and are not set up for workforce solutions

The committee enquiry must take into account the absence of progress by Health Workforce Australia. This initiative has been unable to coherently provide guidance on its funding and participation model for health workforce development. In particular partnerships for regional health workforce development have been repeatedly changed, funding offered then withdrawn and benchmarks for funding requirements changed without notice.

(f) the adequacy of mental health funding and services for disadvantaged groups, including:

(i) culturally and linguistically diverse communities,

(ii) Indigenous communities, and

(iii) people with disabilities;

The Government's arrangements for refugees which are in breach of their obligations under the UNHCR and our long standing treaty regarding the treatment of refugees have created enormous strains on mental health systems dealing with culturally and linguistically diverse communities.

The Government is by it policy of detention adding to the mental health burden of the Australian community.

The training of psychologists to provide services to indigenous community is greatly under resourced and the delivery of mental health services is similarly under resourced.

The mining boom is also creating a large deficit in mental health due to fly in fly out operations and their impact or workers families and their communities.

(g) the delivery of a national mental health commission; and

The debacle that is Health Workforce Australia and the predominance of factional lobbying and special interest groups should serve as a stark warning of the perils ahead for the formation and coherent structure of the commission.

All areas of clinical concern and epidemiological priority should be taken properly into account and all sectors of the Health Workforce should be well represented.

(h) the impact of online services for people with a mental illness, with particular regard to those living in rural and remote locations and other hard to reach groups;

While the internet will be a great force multiplier and service delivery medium it will not take the place of people on the ground.

Funding models have to adequately reflect the tyranny of distance and the resourcing requirements of service delivery in regional and remote Australia

Mental Health needs a human face.

Appendix A

Australian Psychological Society

Federal Budget cuts to the Better Access initiative

Background information, details of the APS audit survey and arguments against Government recommendations for those affected by the cuts
June 2011

Current arrangements under the Better Access initiative

On referral from a medical practitioner, people can access up to 12 sessions of treatment from a psychologist per calendar year.

The referring practitioner may consider that in "exceptional circumstances" the person requires an additional six sessions of psychological treatment (to a maximum total of 18 individual services per person per calendar year).

Exceptional circumstances are defined as a significant change in the person‟s clinical condition or care circumstances which make it appropriate and necessary to increase the maximum number of services.

2011 Federal Budget cuts to the Better Access initiative

From 1 November 2011, the yearly maximum allowance of sessions of psychological treatment will be reduced from 18 to 10, with no exceptional circumstances enabling additional sessions.

Government rationale for cuts:

"The new arrangements will ensure that the Better Access initiative is more efficient and better targeted by limiting the number of services that patients with mild or moderate mental illness can receive, while patients with advanced mental illness are provided with more appropriate treatment through programs such as the Government's Access to Allied Psychological Services program."

The Government has stated that the cuts to Better Access equate to 13% of people treated by psychologists who are seen for more than 10 sessions.

Medicare Australia session data

In the first three years of the Better Access initiative (2007–2009) 2,016,495 unique individuals received services from psychologists under Better Access and **262,144** (13%) of these people received more than 10 sessions of psychological treatment.

APS audit survey of clients seen for more than 10 sessions of treatment
Since the Budget cuts were announced, the APS has conducted an audit survey of Better Access clients seen by psychologists in 2010 who required more than 10 sessions of psychological treatment.

Psychologists providing services under Better Access were invited to participate in the online audit survey and data from **9,900** Better Access clients have been collected.

The vast majority of Better Access clients who required more than 10 sessions of psychological treatment had moderate to severe high prevalence mental health disorders involving depression and anxiety disorders.
Of the clients who required more than 10 sessions of treatment:
80.8% had an ICD-10 mental disorder involving depression or anxiety disorders, also known as „high prevalence disorders".

Only a very small number had a „low prevalence disorder" – **3.0%** had a psychotic disorder and **4.5%** had a diagnosis of bipolar disorder.

On referral, **83.6%** were rated by the treating psychologist as having a moderate to severe (40.5%) or severe presentation (43.1%) and only **0.2%** were rated as having a mild presentation.

42.5% had complex presentations with comorbidity involving another ICD-10 mental disorder, drug and/or alcohol abuse or a personality disorder.

These clients are receiving effective psychological treatment under the Better Access initiative.
At the commencement of the episode of treatment, **83.6%** were rated by the treating psychologist has having a moderate to severe (40.5%) or severe presentation (43.1%) and only **0.2%** were rated as having a mild presentation.

At the conclusion of the episode of treatment, **42.6%** were rated by the treating psychologist as having no residual symptoms (10.2%**)** or a mild presentation (32.4%), while only **2.5%** retained a severe presentation.

Government recommendation for people needing more than 10 sessions
The Federal Budget papers states:

"The new arrangements will ensure that the Better Access initiative is more efficient and better targeted by limiting the number of services that patients with mild or moderate mental illness can receive, while patients with advanced mental illness are provided with more appropriate treatment through programs such as the Government's Access to Allied Psychological Services program."
The Department of Health and Ageing Fact Sheet on the Budget measure states:

"People with severe and persistent mental disorders who require over 10 allied mental health services are still eligible for up to 50 Medicare Benefits Schedule consultant psychiatrist services per annum, or to access the specialised mental health system in each State or Territory."

Arguments against this recommendation
The APS 2010 audit survey of 9,900 clients who required more than 10 sessions of treatment under Better Access shows that the vast majority had moderate to severe or severe mental health disorders involving depression and anxiety disorders, and that they received effective psychological treatment.

These people would be denied access to effective psychological treatment under the Better Access initiative under the proposed funding cuts.

The vast majority of these people would also be denied access to public sector mental health services as they have high prevalence disorders and are not necessarily in need of team-based care.

The recommendation that these people should be referred to a consultant psychiatrist is not realistic as there is a significant shortage of psychiatrists and anecdotally most charge a prohibitive gap fee in the range of $200 per session.

The ATAPS program run through the Divisions of General Practice (DGPs) is not a viable referral option under current arrangements. There is simply not enough funding in ATAPS to provide services for anything like the number of 260,000 people (or 86,000 per annum). A major issue is that a significant proportion of the funding for mental health services received by DGPs is spent on administration rather than providing funding to the psychologists who are engaged to deliver the services. As a result, frequently more junior psychologists are selected to provide services and more experienced psychologists cannot viably undertake the work.

The Government"s own evaluation of Better Access demonstrated that it is a cost-effective way of delivering mental health care. The typical cost of a package of care delivered by a psychologist under the initiative is $753, significantly less than ATAPS which costs from two to 10 times that of Better Access per session. Successful treatment also reduces costs of hospital admissions and allows many consumers to return to work, with the associated productivity benefits.

The data confirm that the Better Access initiative is providing effective treatment for the people it was designed to treat – those with high prevalence disorders.