

29 July 2011

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

Thank you for the opportunity to provide my perspective as a Clinical Psychologist on proposed changes to Commonwealth funding and Administration of Mental Health Services; in particular, the proposed changes to the Better Access program.

Whilst I applaud many of the new mental health initiatives outlined in the recent Federal Budget, I have serious concerns about changes that reduce patient access to treatment by Clinical Psychologists and reduce the overall quality of service provision, particularly for those patients with moderate-severe mental disorders and/or significant co-morbidity and complexity.

Over my 21 years as a Clinical Psychologist I have worked within:

- Public Mental Health Services (both inpatient and community based)
- Community Health primary care programs
- Government contracted roles as mental health / psychology adviser, and
- Private Practice

Throughout my experience across a number of health sectors it has been interesting to note the changes in recognition, referral and treatment accessibility for patients. Since the introduction of the Better Access program I have witnessed much greater treatment accessibility for those with high prevalence mental health disorders, such as depression and anxiety disorders. In addition, I have seen many people with low prevalence mental health disorders, such as Bipolar and Psychotic disorders access more comprehensive services that have improved their treatment outcomes – including better functioning and quality of life.

The Better Access program has led to a considerable change in my private practice case load, with far more low income clients accessing my services. In addition, I have had many more people presenting with moderate to severe (and often complex) mental health problems. This appears to be in part due to GPs better recognising and appropriately referring patients for treatment, as well as the improved access to many patients, who without Medicare rebates (or bulk billing) could not receive specialised clinical psychology services. Also, GPs referring to me are aware of my expertise as a Clinical Psychologist and hence, my ability to work with such patients. Many of my patients present with childhood-onset anxiety disorders (including obsessive compulsive disorder), post traumatic stress disorders, eating disorders, severe depression that has had only moderate response to medication, personality disorders, substance abuse, and/or early trauma histories, as well as other long-standing mental health issues - with associated impairment in functioning.

It is unclear on what basis the decision was made to reduce the number of psychology treatment sessions a person with a mental health disorder can receive each year under the Medicare benefits schedule from a maximum of 18 to 10. No evidence base supporting the reduction in number of sessions was provided. Whilst the February 2011 Better Access Evaluation Report prepared by the University of Melbourne found 75% of patients under the program received 1-6 sessions, this is very different to my clientele, who more often than not use all of their available 12 (or 18) sessions per calendar year. In fact, often my patients would benefit from additional treatment sessions. On occasions I have had to refer patients to Public Mental Health Services to 'hold' until the new calendar year when they can continue treatment with me. Hence, I am very concerned about the effect on such vulnerable patients if the proposed change to reduce the number of treatment sessions proceeds.

The government appears to have argued that the changes to the better Access Scheme will not affect large numbers of consumers as only approximately 13% of Better access patients receive more than 10 sessions. However, this equates to around 86,000 (Lyn Littlefield CEO APS Life Matters 21/6/11) patients per annum, who appear to be the more vulnerable amongst those seen under the scheme. While the government states that these people may obtain services under the ATAPS program, the public health system or from private psychiatrists; these options are not necessarily suitable for this group of patients and are exceedingly limited. I am aware in my local geographic area that most of the psychologists providing treatment under the ATAPs program are not Clinical Psychologists. Therefore, they may not have the necessary training or skills to effectively treat the more severe and complex patients. I strongly recommend that the 18 sessions, including those for "exceptional circumstances", be reinstated under Better Access in the absence of a scheme that provides even better access to Clinical Psychology services for some of the more vulnerable members of the community.

I believe the two-tiered Medicare rebate system needs to be retained as it recognises the value of specialisation in Clinical Psychology. As a Clinical Psychologist, unlike many of my non-clinical colleagues, I have accredited and integrated postgraduate training specifically in the field of lifespan and advanced evidence-based psychopathology, assessment, diagnosis, case formulation, psychotherapy, evaluation and research across the full range of severity and complexity. Many of my patients have been referred to me following unsuccessful treatment by non-specialised psychologists. Clinical Psychologists possess the hospital and clinic-based training and supervised experience that is essential to ensuring the delivery of effective, comprehensive, evidence-based mental health care for patients with complex presentations. Clinical Psychologists have the training and skills required to assess and diagnose conditions when longer term treatment is required, select which treatment modalities are appropriate, provide sophisticated clinical psychology treatments, and know how best to integrate this care with treatment provided by other health professionals (such as psychiatrists, GPs, and other allied health providers).

Some of my patients have been discharged from overwhelmed public mental health services earlier than they would be otherwise because they can effectively continue their treatment with me. At present I am able to bulk bill many of these and other patients who cannot afford to pay for private treatment. If the two tiered rebate system changes and in so doing, reduces the current Medicare rate for treatment by a Clinical

Psychologist, these patients will lose access to my services as I will no longer be able to afford to offer bulk billing.

In summary, I am greatly concerned about the capacity of Clinical Psychologists to provide high quality care under the proposed changes to Better Access. In particular, I hold serious concerns regarding the capacity for treatment of patients with moderate-severe mental disorders and/or significant co-morbidity and complexity. Indeed treatment may have unintended negative consequences for these patients if session limits requires treatment to be ceased prematurely.

Therefore, as outlined above, I strongly recommend the following:

- **that the 18 sessions, including those for "exceptional circumstances", be reinstated under Better Access** in the absence of a scheme that provides even better access to Clinical Psychology services for some of the more vulnerable members of the community; and
- **the two-tiered Medicare rebate system be retained as it recognises the value of specialisation in Clinical Psychology.**

Thank you for the opportunity to express my views to the committee.