22nd July, 2011

Thank you for the opportunity to submit information and comment to the Senate Enquiry into the Commonwealth funding and administration of mental health services. As a Clinical Psychologist in private practice for over a decade, and having worked in mental health in both the public and private sectors for over 20 years, I believe I am in a good position to advocate for those who may be unable or unwilling to advocate for themselves.

I will direct my comments to the following terms of reference:

(b) changes to the Better Access Initiative, including:
(i) the rationalization of allied health treatment sessions
(iv) the impact of changes to the number of allied health treatment sessions for patients with mild to moderate mental illness under the Medicare Benefits Schedule.

(e) mental health workforce issues, including:
(i) the two-tiered Medicare rebate system for psychologists,
(ii) workforce qualifications and training of psychologists.

(b) changes to the Better Access Initiative, including:
(i) the rationalization of allied health treatment sessions
(iv) the impact of changes to the number of allied health treatment sessions for patients with mild to moderate mental illness under the Medicare Benefits Schedule.

Under the Better Access scheme, Australians have been able to access appropriate and affordable care, in a discreet setting for their mental health difficulties. For many it was the first time they had sought assistance. Whilst some presented with only mild or transient problems many with complex presentations, multiple diagnoses, and underlying personality disorders sought assistance. When the Better Access Scheme was introduced there was no limitation of the scheme to those with "mild to moderate" difficulty. The current session limit allows people to access the level of assistance they require.

The proposed changes to the scheme are likely to have the most impact on those with greatest need, that is, those with moderate to severe difficulties, effectively discriminating against those with more complex needs. Those with "mild-moderate" difficulties will retain access to choice of a practitioner based on their needs with regard to presenting issue, cost, available hours, and location. Those with "moderate-severe" presenting issues will not. The alternative ATAPS pathway will not be accessible for all, or provide choice in practitioner, location, or available hours. We are left with the absurd situation where a person who seeks assistance in the second half of the calendar year is likely to gain an effective number of treatment sessions by accessing further sessions in the new calendar year. Someone who falls ill in the first half of the calendar year is not so fortunate. This is a particular issue in my region, where only a tiny minority could afford to access treatment without a rebate. In summary, the proposed changes to funding under the 2011-2012 budget suggest the following: those with mild presentations retain access to choice with regard to location, available hours and selection of practitioner. Those with "moderate-severe" presentations no longer have access to care appropriate to their needs.

I am also concerned about the message of shame these proposed changes send to those experiencing mental health difficulty. For the first time with the introduction of the Better Access Scheme in 2006, Australians were able to access affordable mental health care. This scheme began to break down the shame and secrecy surrounding mental health difficulty. I have had the privilege of seeing many times over the relief (and even, delight) on

people's faces upon the realisation their community and government wanted them to have assistance for their mental health difficulty. The Better Access Scheme, as it has been working put mental health on the same footing as other health difficulties: a realistic stance given the cost to society and to the economy. I am concerned these changes represent a step backwards for our attitudes toward mental health in this country.

A 10 session cap implies this is an adequate number of sessions to alleviate difficulty, despite an extensive research base to the contrary. As a Clinical Psychologist well trained in the delivery of clinically proven, well –researched treatment programmes, I know what it takes to effectively assist those presenting with anxiety or depressive disorders. I also know research indicates clients will benefit from a range of interventions and have sustained improvement if treatment is 16-20+ sessions. I have no evidence-base I am able to deliver such programmes within a 10 session limit - a cap that seems to be dictated by economic modeling alone without reference to clinical reality. This is a covert message of shame sent to those suffering genuine difficulty.

There are those people with severe presentations and complex life difficulty that cannot be effectively helped by a sole private practitioner. These people do require more intensive intervention and support. For this reason I am pleased at the announcement of funding to the Headspace and Eppic models of care and the flexible care packages available under the Tier 3 ATAPS funding. The government is to be congratulated for recognizing a significant gap in available services and moving to fill this gap. However effective mental health care cannot be provided by filling one significant gap and creating another. There are many in our community who require significant assistance but will not qualify for assistance under these initiatives. It is these people who have the most to lose under the changes proposed in the budget: those with a recognizable disorder/s, significant levels of suffering, who can be assisted by directed and timely treatment.

I live and work in outer Western Sydney – an area with a great deal of need, a community with a high level of debt, and life pressures. I am deeply concerned about those who will no longer have access to treatment because they will not be able to afford to pay privately, yet will not fall into the "low income threshold" of the ATAPS scheme. I am concerned I will be facing a situation where my clients will have brief "shots" at therapy, but relapse over time, being unable to create sustained change in their life. This is also likely to place greater pressure on an already overstretched public system.

Under the proposed changes it is suggested those with more severe difficulty can be effectively treated by Psychiatrists or under ATAPS schemes. I would like to address firstly the proposed pathway of referral to psychiatrists. In our region there is a shortage of psychiatrists. People will regularly wait 4 months for an initial assessment by a psychiatrist. Secondly, most psychiatrists do not bulkbill and there is a substantial gap, which is prohibitive for many. Thirdly, not all psychiatrists, perhaps partly due to the shortage in their numbers in this area, and partly due to inclination and training, provide therapy to their patients, but predominantly provide medication management. Fourthly, the proposed alternate pathway of referral to psychiatrists is a more expensive option for the government and for the client.

The second proposed pathway is via referral to the ATAPS scheme. In my area this scheme is limited to those on lowest income, has a 12 session limit, and requires a small co-payment from clients accessing the service. It regularly has insufficient funding to provide services for the entire financial year. Under the current Better Access Scheme I am able to offer services with a modest gap between the rebate and the fee charged ($30). However where the need arises I am able to bulkbill or reduce this gap, depending on the circumstances of the client. Hence, I am able to offer more flexibility to my clients than the ATAPS scheme in my area. Further, it is my understanding the budget provides no new funding for counselling

programmes (tier 1), but the bulk of new funding is directed at the provision of flexible care packages for those with severe and complex needs under tier 3 funding. Once again those with "moderate-severe" difficulties who would benefit from effective, timely, and cost-effective treatments are excluded from access to treatment.

Designing a mental health system that effectively triages at the point of GP contact, separating people who present into mild-moderate, moderate-severe, severe plus levels of severity, may sound appealing but is problematic. Firstly the level of assessment required to make this clinical decision is beyond the scope of the preparation of a Mental Health Treatment Plan, but requires a complex and lengthy assessment. Secondly, it is not always possible to tell at the outset who has mild, moderate, or severe difficulty. Sometimes those with very severe presentations remit quickly, whilst those with mild presentations initially, soon emerge to have many more underlying difficulties, perhaps with underlying personality disorders not previously apparent.

(e) mental health workforce issues, including:
(i) the two-tiered Medicare rebate system for psychologists,
(ii) workforce qualifications and training of psychologists.

The Better Access Review did not find a difference in treatment outcome between treatments provided by Clinical Psychologists and those provided by registered (4 year trained) psychologists. However this cannot be taken as evidence of equivalence in treatment between the 2 groups of psychologists. Whilst the outcome of the Better Access review was interesting it was not designed to evaluate these differences and there are many variables that could account for this finding. The survey did not follow basic guidelines for outcome research. A decision to modify the two-tier system based on the outcome of the Better Access Review would be seriously flawed.

As a person who worked as a generalist psychologist for some years before completing my Clinical Masters degree I am well aware of the differences in knowledge, training, and skills between 4+2 year trained psychologists and those with Masters or Doctorate level training. Whilst there are many very experienced and skilled psychologists and therapists with 4+2 level training, who have made great investment to improve their skills, there is a great deal of variability in the skill-level of people trained to this level. There can be no comparison between the 4+2 level training and that received by those with Masters or Doctorate levels of training. These training courses have as their entire focus training in the assessment, diagnosis, formulation, and treatment of mental illness. There is rigorous supervision and further supervision in the field following graduation. Further many in our field have played leading roles in the development of effective treatment programmes for those with mental illness. To equate this level of skill, with that of the 4+2 pathway is very naïve. A change to the two-tier rebate system will lead in the short-term to a reduction in the quality and choice of services available for those with mental health difficulty. In the longer-term it is likely to act as a disincentive to obtaining high-level training in Clinical Psychology, reducing the effectiveness and skills of the mental health workforce.

Private practice is a challenging role, even for the experienced practitioner. On many days we are making decisions about the safety of our clients and appropriate actions that need to be taken. There is a level of independence in decision-making required in this environment, that is risky for the isolated, underskilled, and inexperienced. A change to the two-tier system would effectively mean encouraging the least equipped people to be in the most demanding roles – a counter-intuitive response.

In summary, the proposed changes to funding under the 2011-2012 budget suggest the following: those with mild presentations retain access to choice with regard to location, available hours and selection of practitioner. Those with “moderate-severe” presentations no longer have access to care appropriate to their needs (unless aged 12-25years, or requiring EPPic services). Those with “severe+” presentations will not have access to choice of location, availability, or practitioner, but will have access to a range of appropriate services. This creates an enormous gap in service provision for those who have much to gain from the provision of effective and timely mental health care. The changes proposed in the budget effectively punish and shame those who need assistance and have much to gain from access to effective treatment: those with complex difficulties, multiple diagnoses, trauma history, and sometimes comorbid personality disorders. Given these are Australians that with effective, low-cost, and timely treatment may be able to be assisted to remain in employment, contribute to their communities, and families the proposed changes are likely to add to the disease burden of mental illness on the Australian economy. The proposed changes to Mental Health funding, whilst offering some important and welcome new initiatives effectively introduce more disparities and barriers to effective treatment into our system of mental health care.