31/07/2011

Committee Secretary
Senate Committee for Community Affairs
PO Box 6100
Parliment House
Canberra, ACT 2600

Dear Committee Secretary,

Re: Inquiry into Commonwealth funding and administration of mental health services.

Thank you for investigating the current arrangements for funding of mental health services by the federal government. I appreciate your review of submissions from the general public.

I am clinical psychologist with over 11 years experience working in both government mental health services and in private practice. I work with clients of all ages across a range of mental health concerns. I am concerned about the cuts to the Better Access to psychology services announced in the recent Federal Budget 2011-2012.

I would like to address a number of the terms of reference of the senate inquiry including:

(a) the Government's 2011-12 Budget changes relating to mental health;
(b) changes to the Better Access Initiative, including:
(ii) the rationalisation of allied health treatment sessions,
(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;
(c) the impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program;
(d) services available for people with severe mental illness and the coordination of those services;
(e) mental health workforce issues, including:
(i) the two-tiered Medicare rebate system for psychologists,

In this submission, I will ask the inquiry to recognise the implications of the government cuts to the Better Access program and reinstate the funds cut from this program.

Summary of Current Services

Better Access to Psychologists

The Better access to psychological services program provides suffers of mental health disorders with up to 18 psychological therapy sessions per calendar year. These sessions are available in 2 sets of 6 sessions with each set of 6 sessions requiring a referral from a medical practitioner such as a GP, paediatrician or psychiatrist. The referring practitioner may then consider whether the person requires an additional 6 psychological therapy sessions under "exceptional circumstances". People with a diagnosed mental health condition may therefore be eligible for **a total of 18 psychological therapy sessions** within a calendar year if deemed appropriate. The current Medicare benefits schedule defines exceptional circumstances apply

where there has been a significant change in the patient's clinical condition or care circumstances that requires further therapy. This allows for flexibility in the care arrangements for patients who may experience additional difficulties during therapy or if they need to change mental health providers during the course of their treatment.

Under the current system a Mental disorder is described as a range of clinically diagnosable disorders that significantly interfere with an individual's cognitive, emotional or social abilities. This includes, but is not limited to, patients experiencing Phobic disorders, Generalised anxiety disorder, Adjustment disorder, Unexplained somatic complaints, Depression, Post Traumatic Stress Disorder, Eating disorders, Panic disorder, Mixed anxiety and depression, and Obsessive Compulsive Disorder. The services are provided by mental health practitioners in private practice under a fee for service model.

The post-implementation review by the Department of Health and Aging (Pirkis et al, 2010) concluded that the costs of an entire treatment course for depression and/or anxiety by psychologists under the program were on average $753.31. The review concluded that the program was reaching members of the Australian public who were experiencing mental health disorders that had previously not accessed services. This increase in access to psychological services was found to be associated with positive outcomes for consumers with pre and post treatment measures of psychological distress indicating a significant reduction in symptoms of mental health concerns at the conclusion of treatment.

In summary, the Better access initiative has increased access to psychological services in the community to people who previously did not receive psychological interventions, in a cost-effective manner with a good effect.

Access to allied psychological services

ATAPs was designed to provided services for those groups that historically have had poor access to mental health care such as remote and rural, indigenous communities, youth and homeless. The program involves the GP referring the patient to an allied health professional with a capped number of focussed psychological strategies at low or no cost to consumers. The structure of the program means that GP divisions or Medicare locals are allocated funds with which to provide mental health services. Psychiatrists currently cannot refer patients to this program.

Federal Budget 2011-2012

The increases in funding to more areas of mental health care are welcomed including increased funding for Headspace sites. However, it appears that the governments increase in funding to some areas has come at the cost of the Better Access system including rebates for GP mental health care plans and reviews and the number of psychological therapy sessions that will receive a rebate under the Medicare Benefits Schedule (MBS). It is noted that the number of sessions eligible for a rebate under the MBS for sessions with a Psychiatrist remains unchanged at 50 sessions per year. These changes are likely to have dramatic reductions in the treatment choices and efficacy of treatments provided for those people experiencing mild through to severe mental health concerns.

A commitment to mental health funding by the Federal government needs to focus on increasing funding for cost effective, evidence based mental health services rather than shifting funding from one area to another. The fee for service model results in tax payers'

money being spent only spent when a service is provided. The concern about funding organisations to provide mental health care is that it results in a significant proportion of funding being spent on administration and associated expenses rather than direct mental health care for the population. The current federal budget is characterised by a shift from the fee for service model of health care for the Australian public.

1. Rationalisation of number of treatment sessions under the Better Access initiative.

In May 2011 the federal budget announced significant cuts to the Better Access program specifically the reduction in the number of available sessions from **18 per year** to **10 per calendar year.** Approximately, 13% of people accessing psychological services under the MBS use 10 or more sessions per calendar year (Pirkis, et al, 2010). This equates to at least 262,144 people based on figures from 2007-2009. These people will be directly affected by the federal government's changes and this group represents those with more severe and complex mental health concerns. It is concerning that the government's proposed changes will negatively impact on those in most need of mental health treatments. I will address a number of concerns associated with the rationalisation of treatment sessions.

Absence of Empirical Evidence

The reduction in the number of sessions available for MBS rebates appears to have been made without public consultation and without a review of the empirical data to justify such changes. Indeed, the rationalisation of treatment sessions has been made despite the positive findings of the Government funded review of the Better Access initiative (Pirkis et al, 2010).

The post-implementation review commissioned by the Department of Health and Aging (Pirkis et al, 2010) concluded that the costs of an entire treatment course for depression and/or anxiety by psychologists under the program was on average $753.31. The review concluded based on these figures that Better Access provides good value for money in terms of MBS costs to the government. The review made mention of the significant uptake of the program and the costs to the government, and concluded that these should be viewed positively as it indicates that a previously unmet need is now being met. The government has neglected mental health services for many years and the Better access program has offered increased access to effective treatments for the Australian public. It is therefore not surprising that the better access program has seen a large uptake in service by the public, hence filling previous gaps in services.

The review reported that typically people accessing the services under the Better Access initiative did not have mild symptoms, but that most people accessing services have clinically diagnosable disorders, primarily depression and or anxiety. The review found that most people seen under the program had significant levels of psychological distress. This finding contradicts many critics' statements that the Better Access initiative was servicing the "worried well".

The reduction in sessions is not driven by the peer reviewed empirical literature which has examined the number of treatment sessions required to provide effective psychological interventions for high prevalence mental health concerns. The Australian Psychological Society (2010) review of evidence-based psychological interventions provided a comprehensive review of controlled treatment studies. The review evaluated evidence from randomised controlled trials where psychological treatments were applied to consumers with

mental health disorders such as anxiety and/or depression. The review identified that 15-20 sessions of cognitive behaviour therapy (CBT) and interpersonal therapy (IPT) are required for high prevalence disorders such as anxiety and depression.

A recently published study by Harnett et al (2010) examined the number of sessions required to achieve clinically significant change for consumers receiving psychological therapy at two Australian University psychology clinics. The authors of this study concluded that an estimated 14 sessions were required for 50% of consumers to achieve clinically significant change. For those clients who commenced treatment with moderate to severe mental health concerns, a total of 23 sessions of psychological treatment were required to provide clinically significant change for 70% of clients in the study. Consequently, the authors concluded that financial benefits may be obtained from setting session limits for governments but that such limits would disadvantage most clients, especially those with increased levels of distress who may require more sessions.

Consequently**, the government's rationalisation of treatment sessions available under the Better Access program is inconsistent with empirical evidence which evaluates the number of sessions required to produce clinically significant change for high prevalence mental health concerns.** Consequently, it is likely that people will be unable to access the required number of treatment sessions to effectively receive psychological treatments that will not only reduce symptoms in the short-term but also reduce the likelihood of relapse in the long-term.

Decreased Flexibility in care arrangements

Removal of exceptional circumstances from the Better access initiative removes flexibility in the care arrangements and disadvantages those patients with mild, moderate and severe mental health concerns. People with mental health concerns who experience life events during treatment which result in these consumers requiring more treatment sessions and this group will be disadvantaged under the rationalisation of treatment sessions. For example, consumers who experience a crisis during treatment such as losing a job, experiencing a trauma, death of a family member or close friend and even those who move house, or whose therapist takes leave will be unable to access the required number of treatment sessions to address their mental health difficulties. These consumers may require additional sessions to manage such circumstances or treat additional mental health concerns that may develop. Under the proposed changes these people will be unable to access flexible care arrangements under the Better access initiative.

Ethical Concerns

The reduction in sessions poses a number of ethical concerns for psychologists providing treatments under the Better Access initiative. The rationalisation of treatment sessions may have negative consequences for consumers presenting with mild, moderate and severe mental health concerns if the session limits mean that treatment is ceased prematurely. For example, ceasing treatment prematurely may reinforce patterns of isolation, rejection, abandonment and hopelessness for these consumers. Ceasing treatment prematurely because the consumer is unable to afford additional sessions required to treat their mental health concerns may experience an exacerbation of their difficulties and be unable to access affordable mental health care once they have used 10 psychological therapy sessions subsidised by the MBS.

Psychologists will now need to assess the implications of commencing therapy with someone who is unable to afford the required course of treatment for their mental health concerns.

Implications for current clients accessing services

There are implications of the rationalisation of treatment sessions for those consumers who are currently receiving services under the Better access system. The reduction in treatment sessions are due to commence on November 1, 2011. This will mean that consumers who have received more than 10 psychological therapy sessions between January 1 and November 1, 2011, will not be unable to access further MBS rebates for psychological therapy sessions for the remainder of the calendar year. This may result in an increased likelihood of relapse or patients terminating treatment without experiencing a full remission of symptoms. These patients are unlikely to be eligible for treatment through other services such as state and territory mental health services as they are unlikely to meet the criteria or require team-based mental health care. Those consumers from low-socioeconomic groups, rural areas or those with no private health insurance will be unlikely to be able to afford to cover payments for treatment until January 1, 2012. This may result in an increased need for psychological therapy session under the better access system in the following year, increased hospital admissions and most concerning may lead to increased suicide rates as patients feel abandoned by the system.

Changes to target population for the Better Access Program

The government appears to be proposing that while the Better Access review suggested that people accessing the service that the program will now only target those with mild to moderate mental health concerns. Pirkis et al (2010) reported that only 20% of consumers recruited for the evaluation were experiencing mild to moderate levels of psychological distress. Consequently, 80% of consumers will no longer meet criteria for the program and will need to be serviced elsewhere under the changes to the target group of mental health consumers seen under the Better Access program. The government has proposed that these consumers would be better served by state and territory mental health services, private psychiatrists or through the Access to Allied Psychological Services program. The problems associated with such a proposal are detailed later in this submission.

2. Implications of the rationalisation of mental health treatment sessions for mild to moderate mental health concerns

The rationalisation of treatment sessions will impact negatively on those consumers with mild to moderate mental health concerns in a number of ways. I will review a number of possible negative implications.

Unrealistic Expectations

The reduction in the number of available sessions to 10 per calendar year by the government sets up an unrealistic expectation for consumers and referrers that mild to moderate mental health disorders can be treated with 10 sessions. As previously reviewed, this is not consistent with the empirical treatment literature which indicates the number of treatment sessions required to treat such mental health difficulties. This may result in consumers feeling that they have failed in therapy when their difficulties have not been resolved within

the 10 sessions. This could potentially lead to further exacerbation of consumers' mental health difficulties and further costs to the health system and the Australian taxpayer.

Disadvantaging Low socioeconomic groups

Only those consumers who are able to afford to pay for additional sessions out of pocket or through private health insurance would be able to complete the required number of sessions to resolve their mental health concerns. This likely to result in many consumers receiving incomplete treatment, possible exacerbation of mental health difficulties, decreased effectiveness of the program overall and increased chances of relapse of mental health concerns. Only those in higher socio-economic groups will be able to benefit from psychological treatments provided under the Better Access initiative and who can continue with treatment through private health insurance.

Increased barriers to treatment

The Better access review (Pirkis et al, 2010) reported that consumers concerns about the Better Access system focused around the restricted number of sessions available under the system even when a total of 18 psychological therapy sessions are available. Therefore, it seems likely that the governments' current rationalisation of the Better Access system will further exacerbate consumers concerns about the number of available treatment sessions and experience of treatment under the system. There are many barriers that restrict access to psychological treatment within the community including stigma, requirement for referrals from GP's, and waiting lists for government services. The government's rationalisation of treatment sessions subsidised by the MBS and reduction in rebates for GP mental health care plans are likely to increase barriers to treatment for many members of the Australian public with mental health concerns.

3. Implications for those with severe mental health disorders

There are significant implications for those consumers' who are currently receiving services or who may require psychological services in the future. The Better access review reported that 80% of consumers receiving treatment under this program were experiencing high or very high levels of psychological distress (Pirkis, et al., 2010).

The APS audit survey of clients seen for 10 or more sessions of treatment found that 80.8% of clients presented with high prevalence disorders, 83.6% of these consumers were rated as having moderate (40.5%) or severe (43.1%) presentations. Only 0.2% of consumers with mild presentations were seen for more than 10 sessions. Of those consumers who were seen for more than 10 sessions, 42.5% had complex presentations with co morbidity involving other ICD-10 diagnoses, drug or alcohol abuse or a personality disorder. "The survey found that following treatment 42.6% of consumers had no residual symptoms or mild symptoms. Only 2.5% retained a severe presentation" (APS, 2011). Therefore, it may be concluded that under the proposed rationalisation of treatment sessions that this group of consumers would be unable to access effective treatment for their mental health concerns.

The current proposed changes are likely to result in increased gaps in mental health service provision for the most vulnerable members of the population. The Department of Health and Ageing fact sheet on the budget measures 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 able to access the specialised mental health system in each State or Territory". Such a proposal does not provide adequate or accessible mental health care for this group of the population and further stigmatises and provides increased barriers for treatment. It is unclear that alternative treatment options proposed by the government, such as ATAPS, are unlikely to be sufficiently funded as of November 1 2011 to meet the needs of consumers with severe mental health difficulties who will no longer be able to be serviced under the Better Access initiative. I will address each of these proposed alternatives in turn.

Access to Allied Psychological Services

Financial Implications

The costs of Psychological Services provided under ATAPS are more expensive for the Australian taxpayer than those provided under the Better Access system. The governments own review of the Better Access initiative reported that psychological services provided under ATAPS cost the Australian taxpayer between two and ten times that of those services provided under the Better Access initiative (Pirkis, et al., 2010). The median cost of a psychological therapy session under ATAPS has been reported at $171 per service in comparison to an average of $80 per session for Better Access (Russell, 2011). The Federal government changes mean that ATAPS may need to accommodate an additional 86,000 people per annum who will no longer be able to be access appropriate treatment under the Better Access initiative. A conservative estimate of the costs of 12 psychological therapy sessions for 86,000 people per year would require an increase in funding for ATAPS of $177 million dollars per annum (approximately $882 million/five years) to accommodate the increased number of people accessing this service. This does not take into account ATAPS requirement to target hard to reach populations such as children and adolescents, indigenous populations and rural and remote areas. Consequently, ATAPS will now be required to juggle the different needs of hard to reach populations and now those with more severe mental health disorders with minimal increases in funding.

Implications for Consumers

There are a number of implications of such a proposed change for consumers of mental health services. Those consumers with more severe mental health concerns who require more than 10 sessions under Better Access will need to be transferred from their current mental health professional to a professional who is contracted to work under the ATAPS program. In many regions this will mean that consumers will be required to change psychologist to access sessions under ATAPS. For many consumers, particularly those with more severe mental health concerns, such a change in therapist would be detrimental to their mental health and result in an increased number of treatment sessions being required to complete treatment. A change in therapist during treatment will require a second assessment to be completed by the new psychologist, and a number of sessions to establish trust and a working therapeutic alliance with a new mental health professional. It is unfair and discriminatory to require those consumers with the most severe mental health difficulties to go through this difficult process. This change is also likely to lead to unnecessary increases in costs to the ATAPS program due to replication of assessment services. In addition to costs associated with change in therapist during treatment, the additional GP referrals that would be required for consumers to transfer from the Better access initiative to ATAPS will also result in increased costs to the Australian taxpayer.

I have been informed by the ATAPS coordinator in my local area that services under ATAPS can only be provided to clients who reside in the division's catchment, who see a GP within the division and can then only be referred to a psychologist within the divisions' catchment. Such strict criteria limit the choice of psychologist and the choice of GP for consumers. For example, if a consumer currently has a long-term family GP who is outside of the division in which they reside they may be refused services under ATAPS. This also assumes that the psychologists recruited by the GP division are suitable skilled and qualified to meet particular clients needs.

Additional concerns about this proposal relate to the tendency for low fee providers under ATAPS to be more likely to be less experienced and less qualified (ATAPS review reference). Consequently, consumers who are experiencing severe mental health concerns who may need to access mental health services under ATAPS may be seen by mental health practitioners who are less experienced and less qualified to work with severe, complex and enduring mental health concerns.

State Government Mental Health Services

State government services in WA typically will not accept referrals for patients with high prevalence disorders such as anxiety or depression unless there is significant risk or harm to self or if the patient requires team-based care. Consequently, many of those consumers who will no longer be able to receive an adequate number of treatment sessions under Better Access will be unlikely to be accepted for treatment with state government services. Many of these consumers with high prevalence disorders are not in need of team-based care provided by these services.

Psychiatric care

Psychiatry plays an important and central role in the treatment of severe mental health concerns. However, the proposal that those who can no longer be seen under Better Access due to the rationalisation of treatment sessions can be managed by psychiatry is problematic for a number of reasons. Firstly, the number of psychiatrists per head of population is low meaning that Psychiatrists are thin on the ground, particularly in WA and in the area of child and adolescent mental health. As a result of the shortage of Psychiatrists in private practice they often have long waiting lists (3-6 months).

Secondly, the cost to the MBS is high with patients being able to claim up to 50 sessions per annum at a MBS rebated rate of $370.20 for an initial assessment and approximately $138.00 for follow-up sessions. It is noted that in 2007-2008 the cost to the taxpayer for Medicare rebated sessions for psychiatry was greater than that of clinical psychologists and generalist psychologists combined (National Mental Health Report 2010).

Thirdly, the out of pocket cost per session to consult with a Psychiatrist is high with many clients reporting an average out of pocket expense of $200/per session to visit their psychiatrist. Such out of pocket expenses make psychiatric treatment unaffordable for many Australians to access weekly psychiatric treatment sessions.

Finally, the Governments proposal assumes that clinical psychologists and psychiatrists are interchangeable and provide the same treatments. While some Psychiatrists provide cognitive

behavioural therapy, interpersonal therapy or psychodynamic treatment approaches, the main approach to treatment of mental health concerns adopted by psychiatrists involves pharmacological treatment. The empirical treatment literature has repeatedly shown that psychological treatments alone or in combination with pharmacological treatments for disorders such as anxiety and depression are as effective as or more effective than pharmacological treatments alone and are more cost effective than pharmacological treatments (Sado et al, 2009; Sava, Yates, Lupu, Szentagoti, & David, 2008; Vos, Corry, Haby, Carter, & Andrews, 2005). The assumption that treatment by a clinical psychologist may be simply replaced by that of a Psychiatrist is flawed and it is not a more cost effective solution to mental health care for the Australian Government.

4. Two-Tiered system

The current MBS system for rebates for Psychologists providing treatments for mental health concerns involves a two-tiered system where those psychologists holding an Endorsement in the area of Clinical Psychology are able to bill for psychological treatment sessions under the MBS with a rebate of $119.80. Those Generalist Psychologists who do not hold an endorsement in the area of Clinical Psychology are able to bill for focussed psychological therapy items under the MBS with a rebate of $81.60 attached to these services. The two-tiered system reflects differences in qualifications and training for those psychologists with specialist post-graduate training in the assessment, diagnosis and treatment of mental health disorders.

1. Generalist Psychologists

The group of Generalist Psychologists include a varied group of psychologists with a range of qualifications. The group of Generalist mental also includes psychologists and other mental health professionals who do not have post-graduate qualifications in mental health assessment and treatment. The group also includes psychologists and other mental health professionals with post-graduate training in psychology such as counselling, neuropsychology, health psychology, and forensic psychology. These groups of professionals are currently unable to access specialist rebates under the MBS. As the training and experiences of this group as a whole are varied and I am not aware of the specific details of the qualifications and training of this group and do not wish to comment further on the eligibility of this group for specialist rebates under the MBS. This is a matter for the government and appropriate professional bodies to determine based on a review of the training, qualifications and standards of each profession.

2) Clinical Psychologists

As a Clinical Psychologist, I would like to review the specific skills and training required to register as a Clinical Psychologist to highlight our unique and important role in mental health care within the community. Clinical Psychologists are often grouped with “allied health” for administrative purposes and this has led to a mistaken belief that there is sufficient commonality between this profession and other allied health professions to treat all groups similarly. The training of Clinical Psychologists differs in many ways from other allied health professionals. Clinical Psychologists have a minimum of six years full time university training with two additional years of mandatory professional supervision under the auspices of The Psychologists Board of Australia. Within recent years more and more students are completing either a Doctorate of Psychology with an additional formal year of training at the university, or a PhD in Clinical Psychology and thus adding a further two to three years to their formal university training.

Post-graduate university level training programmes for Clinical Psychology must be accredited by the Australian Psychological Society. This requirement insures uniform standards of excellence in Clinical Psychology training throughout Australia. Once the graduate has completed an accredited programme of studies, s/he must register with The Psychologists Board of Australia to undertake a further two years of additional clinical work under the rigorous supervision of an experienced Clinical Psychologist. When the individual has completed this period of supervised practice, and only when this has subsequently been accepted by The Psychologists Board of Australia, is the individual accredited with an endorsement to practice in the area of Clinical Psychology and eligible for MBS rebates for Clinical Psychology services. To further ensure quality of care, it is a mandatory requirement of the Australian Psychological Society and The Psychologists Board of Australia that all Clinical Psychologists adopt the ethical code of professional standards of conduct and engage in regular professional development and professional supervision.

During the **minimum of eight years of training**, the emphasis of Clinical Psychology is on severe mental health problems during the last four years of training. Clinical Psychologists have extensive training in the theoretical and conceptual understanding of mental health problems, the correct diagnosis and clinical evaluation of these problems and effective management and treatment of mental health concerns. Other than psychiatry, Clinical Psychology is the only mental health profession whose complete post-graduate training is in the area of mental health. Consequently, due to their theoretical, conceptual, empirical and applied competencies, Clinical Psychologists are specialists in the provision of psychological therapies for mental health disorders. As a result of their training, Clinical Psychologists have a thorough understanding of varied and complex psychological theories and have the ability to formulate and respond to both complex disorders and to novel problems, generating interventions based on this solid knowledge base. This very high level of specialist competence of Clinical Psychologists is acknowledged by all private insurance companies who recognise Clinical Psychologists as providers of mental health services.

In 1995 the British Psychological Society and the Royal College of Psychiatrists published a joint statement about the need for psychological therapies in the National Health Service (NHS) of Great Britain. This was a collaborative venture by the two professions who cumulatively provide most of the formal psychological therapy services for people with severe mental health disorders. The conclusion arrived at, after due consultation and review of evidence supported practice, was that psychological therapies were an integral part of both Psychiatry and Psychology and as such, are essential components of effective, co-ordinated mental health care.

The Better Access evaluation reports effectiveness of treatments provided by clinical psychologists and general psychologists under the initiative. The study found no difference in the clinical outcomes for consumers of Clinical Psychology services or services provided by Generalist psychologists. This finding must be considered within the methodological limitations of the study to evaluate differences in the treatment outcomes for consumers who received services by Clinical Psychologists and generalist Psychologists. Firstly, the researchers are unable to provide statistics about the number of generalist psychologists recruited for the study who has completed post-graduate education in mental health assessment and treatment. Secondly, the sample size is small with a total of 41 clinical psychologists providing data for the study compared to 49 Generalist psychologists. Such a small sample size may be unable to provide sufficient data to provide a thorough comparison

of the treatment effects for each group. Specifically, the sample may not be large enough to demonstrate reliable differences in treatment effects across the two groups of psychologists. Thirdly, the clients who provided data were selected by the clinicians thus introducing some bias in the sample selection. Consideration of the two-tiered system of rebates should therefore interpret the data about the outcomes for consumers of clinical psychologists and generalist psychologists with caution.

Any changes to the two-tiered system of rebates for psychologists, such as eliminating the higher rebate provided for psychological therapy services provided by clinical psychologists, would result in financial implications for consumers of clinical psychologists. If such a change was paired with a reduction in the number of sessions available then this would severely disadvantage this consumer group.

The two tiered system of rebates for psychologists under the MBS should remain. Any changes that may be considered to the two-tiered system of rebates for psychologists needs to consider evidence and information about the training, qualification and standards both within Australia and throughout the world.

<u>Recommendations</u>

- Reinstate the 18 eligible sessions that attract a Medicare rebate for psychological services under the Better Access system.

- The number of sessions available should be reviewed to ensure that the number available is consistent with the research into effective treatments for high prevalence disorders such as anxiety and depression

- Focus ATAPS funding on hard to reach populations and reduce the replication of services between Better Access and ATAPS.

- Retain the current two-tiered system of rebates for psychologists under the MBS.

In summary the cuts to the number of sessions that will attract a Medicare rebate for psychology services provided under the better access system reflect the smallest saving to the governments' mental health budget yet will result in the greatest negative consequence to the mental health care of patients using the service.

Yours Sincerely,

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