

Committee Secretary
Senate Standing Committees on Community Affairs
Parliament House
Canberra

**Submission re: Commonwealth Funding and Administration of Mental Health Services:
Proposed cuts to the Better Access Initiative**

I am a clinical psychologist who has worked for many years in senior positions in the public sector. I now conduct a part-time private practice, in which most of the people I see are referred under Better Access. These people would not be able to afford to see a psychologist were it not for this initiative, and neither would they be able to obtain the treatment they require under the public system. The referring GPs in my area refer more severe and complex cases to me, as a clinical psychologist, in accordance with the initial intent of the initiative. All my clients present with severe affective disorders, including major depression - recurrent, some with a history of suicidal episodes – and/or disabling anxiety disorders. Complications, including a history of early complex trauma and/or serious health conditions exacerbated by the person's mental state, and/or substance dependence, are practically always also present. On initial referral the majority of these people are either not working, or working in only a limited capacity, because of these disabling conditions.

The Government's 2011 National Mental Health Reform document delineates the significant burden of disease of mental illness in Australia, and acknowledges the success of the Better Access Initiative. However, it makes the point that it considers that the program has targeted only those with "mild to moderate" disorders. It states that the population which it refers to as suffering "severe and debilitating" mental illness cannot be served by the program. In doing so, and judging by the statistics quoted, the document appears to reserve the category "severe and debilitating" for the psychoses and other low prevalence disorders. The literature varies on the definition of this term, at times adopting the above meaning, but also recognising that there is a very significant group of people with severe, complex and long term disorders who require special recognition. It is the experience of clinical psychologists who provide services under Better Access that most people referred to them under this scheme present with severe and complex disorders, such as described above. These disorders can be effectively treated by skilled clinicians using advanced cognitive behaviour therapy interventions, with great cost-benefit.

I believe the document errs in not considering this important third category: those people presenting with severe and complex disorders.

I wish to make the following submissions in relation to the terms of reference (b)(ii) and (e)(i):

Proposed reduction in the number of sessions available under the scheme (b)(ii)

Throughout my career I have been always very mindful of the need for cost-effectiveness of services. Sometimes very effective interventions can be conducted in a relatively small number of sessions, and this is always my goal where possible. However with the severe, complex cases described above this is not possible. Practical experience, as well as evidence from the literature, shows that these people require a minimum of 12 sessions. In some cases even the current absolute maximum 18 sessions is not sufficient.

However when the person receives the necessary number of sessions of evidence-based treatment very significant gains are made, with significant flow-on effects, not only in reducing the disabling emotional distress for the person and his/her family, but also in improved physical health, return to work or increased hours worked, reduced hospital admissions and reduced need for medication. Prevention can flow on too, in improved capacity for effective parenting.

To cut the maximum number of sessions to 10 would significantly reduce the efficacy, and thereby the cost-effectiveness, of this program. Indeed the effect of the proposed system would be that only those people with disorders in the mild to moderate range could be seen.

If this were the case where would these many more severe people go? From my long knowledge of public health services I know that these programs are not designed for this category of patient, neither is the required expertise usually available. Private psychiatrists are much harder to access than clinical psychologists, are even less available in regional and remote areas, and their fees, and presumably rebate costs, are higher. The ATAPS program provides only access to focussed psychological strategies.

Summary:

I believe it is important to follow the initial concept of the initiative: The more severe, complex patients need to be seen by psychologists with advanced specialist skills in treating such disorders – that is, by clinical psychologists. The referring GPs, through their knowledge of the patient and guided by measures such as the K10, are in a position to make these referrals appropriately. The present number of sessions, ie up to 18, should be available to clinical psychologists to see these more difficult, severe cases. I believe that this model provides a highly cost-effective service for this complex and severe group, who are not otherwise catered for in the Government's proposal.

Proposed abolition of the two-tiered Medicare rebate system for psychologists (e)(i)

The proposal is to cut the rebate available to registered clinical psychologists, who have completed 6-8 years' training, including 2-4 years of specialist training in clinical psychology, and who have demonstrated proficiency in all aspects of this speciality, to the same rebate

as that for generalist psychologists who have not undertaken specialist training and demonstrated this proficiency.

In my many years of supervising postgraduate students and interviewing applicants for psychology positions, the benefits of clinical training/qualifications have been very clear. When presented with the details of hypothetical cases, applicants with clinical qualifications demonstrate far greater acuity in case conceptualisation, proposed treatment plans, and evaluation methodology.

I believe that the Medicare system in general sets rebates to health professionals according to their degree of speciality. In the public system clinical psychologists are eligible for specialist positions, with a commensurately higher level of remuneration. Given these precedents it is very hard to understand the justice and advisability of the proposal.

Summary:

I believe it is essential to retain the two tier rebate system.