

Summary

WHO recommends that mental health care is available at the community level for anyone who may need it.

(Mental Health, Human Rights and Legislation: WHO's Framework)

- I am making this submission from the point of view of a clinical psychologist who is passionate about universal access to effective evidence-based psychological therapy.
- Any diagnosed mental disorder has a significant impact on the person's life. The use of terms such as mild or moderate, can suggest a mild illness - this is not the case.
- Better Access for the first time, provided Australians with universal access to effective evidence-based psychological treatment for people with mental health disorders for up to 18 sessions per calendar year. This is in contrast to specific government programs. It is like Swiss cheese where the holes represent specific government programs, and the cheese represents the Better Access program that fills in all the gaps between the hole
- My experience is that Better Access has been extraordinary, akin to giving a blind person a cataract operation. For clients its effect has been similar to a major medical breakthrough - they have finally received effective treatment from what have been disabling disorders, rather like the effect of putting a major new class of drugs on the PBS. Most of the clients I see, many of whom are over 40, have not previously had evidence-based psychological therapy. Most who completed therapy, often more than 10 sessions, showed significant, sustainable improvements in their mental health which has allowed them to engage in normal Australian life.
- The recent evaluation of Better Access confirmed that Better Access delivers cost effective, effective services to people that had not previously accessed psychological therapy. (Pirkis et al, 2011)
- Better Access also provides clients with a choice of therapist, allowing psychologists to specialise, and clients to find a good fit in terms of demographics, ethnicity, cultural knowledge etc. Clients need to feel comfortable with the psychologist as the therapeutic relationship is an important part of therapy.
- Evidence-based therapy (frequently Cognitive Behavioural Therapy "CBT") is the internationally recommended treatment for most common mental health disorders either alone or conjunction with medication. CBT evidence-based practice requires 8 to 20 sessions to treat one uncomplicated disorder, after diagnosis, assessment and treatment planning.

Effect of cutting the maximum sessions from 18 to 10 per calendar year

- Accepted good therapy practice requires at least one session for assessment and at least one final session to address relapse prevention /termination issues, i.e. **10 sessions provide only 8 actual treatment sessions**.
- The current program provides a maximum of 16 treatment sessions (after subtracting 2 sessions), i.e. **the changes represent a reduction of 50% in the number of treatment sessions from the current program**.
- **For co morbid disorders the proposed 8 treatment sessions represents**
 - 4 sessions for somebody with 2 disorders (eg social anxiety and depression)
 - **2.7 sessions per disorder** for somebody with 3 disorders (eg social anxiety, depression and mild substance abuse); etc. This is clearly inadequate - we are not miracle workers!
- 10 sessions does not cater for clients that need extra sessions in case of relapse or because clients had to change psychologist

- A maximum of 10 sessions is inconsistent the consensus of mental health experts about the number of sessions needed for effective therapy for most common mental disorders, as well as other government funded programs.
- **A maximum of 10 sessions is in clear conflict with the recent guidelines for the treatment of Post Traumatic Stress Disorder(PTSD) put out by the government funded Australian Centre for Posttraumatic Mental Health.** They recommend 8-12 90 minute treatment sessions following diagnosis, assessment and treatment planning. They state "where adults have developed PTSD and associated features following exposure to prolonged and/or repeated traumatic events , more time to establish a trusting therapeutic alliance, more attention to teaching emotional regulation skills and a more gradual approach to exposure therapy may be required ." i.e. more sessions may be required. (Australian guidelines for the treatment of adults with ASD and PTSD,2007, p21)

Who does this affect

- The number affected is likely to be around 86,000 people per annum (Lifematters , 21.6.11), which compares with annual deaths from cardiovascular disease 48,456 (2008) (AIHW, 2011).**The numbers are not small.**
- The cutbacks penalise people who have not previously had access to mental health care and who cannot pay for additional sessions including those in areas of lowest socioeconomic disadvantage.
- **Clients who have completed 10 sessions have gone through a selection process that makes them one of the most effective groups to treat** (they are prequalified in marketing terms) They have a mental disorder that is treatable by psychological therapy, they have turned up for therapy, they have been committed enough to complete 10 therapy which can be challenging (see section 1.2.3), and there also needs to be an expectation of benefit from further therapy to obtain the additional sessions. Generally clients who complete 10 sessions , **are not those who would be better treated elsewhere - therapy is working.** This is in contrast to clients who drop out, some of whom **might be better treated in a different service.**
- **There are no alternate services that are likely to be able to cope with 86,000 people.** Better Access was set up because existing services did not have adequate capacity to provide primary mental health treatment. They are still unlikely to have sufficient capacity. The new programs will in general not provide treatment for those currently receiving more than 10 sessions.

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| <ul style="list-style-type: none"> • The only cost of keeping a maximum of 18 sessions is the cost of the sessions of the people who use it. If more suitable services are available elsewhere then the GP will refer clients to it , and there will be no cost to Better Access. Only if Better Access is more suitable will clients be referred to it and the Better Access program incur a cost. |
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Socioeconomic disadvantage

- Mental disorders occur across all socioeconomic groups and cause a high burden of disease. People in all socioeconomic groups require effective evidence-based treatment.
- There is no indication that there is any overservicing in any socioeconomic area

- On an age adjusted basis, the gap between services provided to those in the highest and lowest quintile of lowest socioeconomic disadvantage is closing , it was 11% in 2009 down from 27% in 2007.
- Clinical Psychologists charge just 49 cents above the average fee, averaged across all payments, compared to GPs charging \$1.48. (Clinical Psychologists have lower bulk billing rates but this is because the Medicare rebate for a Clinical Psychologist is 85% of the scheduled fee, compared to 100% for a GP.)

Economic considerations

- Clinical psychologist working under Better Access are the most cost effective way of providing psychological therapy compared to the public sector, ATAPS and psychiatrists
- The cost of providing the maximum 8 sessions that have been cut back is \$958 for clinical psychologists, but the potential savings are greater - the cost is equivalent to just 4 weeks of centrelink Newstart payments
- Changes to the Better Access scheme mean that we will have the odd situation where people with short term mental health disorders or easily treated disorders will receive effective psychological treatment with 10 sessions available to them, and eventually those with serious and persistent mental illness with complex needs will be catered ,for but not those clients in the middle.

ATAPS

- More expensive, capped i.e. rationed ATAPS services, duplicate Better Access services in some areas and being area based, limit choice of psychologist .
- GP's provide effective coordination for the mentally ill and are the most appropriate coordinators
- **Two tier payment system:** Clinical Psychologists have significantly different training to general psychologists and other specialist psychologists as illustrated in the NSW award and information from the Australian Psychological Society's website, and as such are better able to provide effective treatment, especially for more complex cases.
- Remote or underserviced areas- there need to be medicare items to allow psychologists to provide Skype or other video conferencing sessions. .
- The 2011 Budget changes to mental health have focussed on the provision of capped i.e. rationed, special purpose programs whilst significantly reducing services under the Better Access universal access scheme. This is significant move away from the Medicare ethos of providing effective treatment for all and the WHO recommendation " **that mental health care is available at the community level for anyone who may need it**"
- Better Access is a proven scheme , delivering cost effective services , and needs to be at least retained in its current form with 18 sessions, or preferably expanded to provide sufficient sessions for evidence- based therapy.

Finally, when someone has a physical illness say a non life threatening infection, we don't say to them we will give you one course of antibiotics but if you don't respond we won't give you a longer course even though we know it is very likely to help you, and oh by the way if you happen

to get another infection this year or the current one returns we won't treat it – why are we doing this in mental health?

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Reason for the submission and background

Analysis of Australian mental health care has tended to look at the big picture, the aggregate dollar amounts, total number of patients etc but this obscures the effects of budget changes on individuals. I would like to look at it from the perspective of a clinical psychologist working with adult clients in the inner city areas of Sydney. I mainly see clients from five electorates (Grayndler, Kingsford Smith, Sydney, Watson, Wentworth) and a small number of clients travel from outside this area to see me.

I bulk bill approximately 40% of clients and nearly all of the remainder would be unable to afford the cost of therapy without the Medicare rebate. However a small percentage of my clients come from the more affluent suburbs of Sydney so that I have a good perspective of the effects of Better Access on various socioeconomic groups.

I have been practising as a clinical psychologist for 6 years and have a predominantly CBT orientation.

I am passionate about the future of evidence-based psychological therapy and universal access to effective evidence-based psychological therapy.

Responses to specific parts of the enquiry

1. Changes to the Better Access Initiative

In order to evaluate the effect of the proposed changes to Better Access it is important to first evaluate the current scheme.

1.1 The Current Better Access scheme

Better Access provided for the first time, universal access to psychological treatment for people with mental health disorders for up to 18 sessions per calendar year. Evidence-based psychological therapy is the recommended treatment for a number of common mental health disorders either as a standalone therapy, or in conjunction with medication (Barlow (2001).

1.1.1 Better Access Clients and Outcomes

As a Clinical Psychologist, practicing in the Sydney inner city area, my experience is that **Better Access has been extraordinary, akin to giving a blind person a cataract operation**. For clients it's effect has been similar to a major medical breakthrough - they have finally received effective treatment from what have been disabling disorders, rather like the effect of putting a major new class of drugs on the PBS. For the first time, Australians, regardless of their financial situation have had access to effective, evidence-based psychological treatment for common mental health disorders. I see people in their 40's and 50's who have lived with mental health disorders for many years because, until now, they could not afford treatment.

Most of the clients I see have not previously had evidence-based psychological therapy but most who completed therapy, usually more than 10 sessions, showed significant, sustainable improvements in their mental health. Not only did they have a better quality of life, but once freed of the prison of mental disorders, they were able to flourish and engage in the normal aspects of Australian life. They have started studying, started employment, applied for more challenging roles at work, started exercising, stopped smoking, made friends, started relationships, had children etc.

PLEASE SEE CONFIDENTIAL ATTACHMENT FOR EXAMPLES OF CLIENT OUTCOMES FOR CLIENTS RECEIVING MORE THAN 10 SESSIONS.

These experiences are in line with the evaluations that have been conducted to date (Pirkis et al, 2011) with findings that the scheme treated people with significant mental health problems, clients received effective treatment and the scheme reached people that had not previously received psychological treatment.

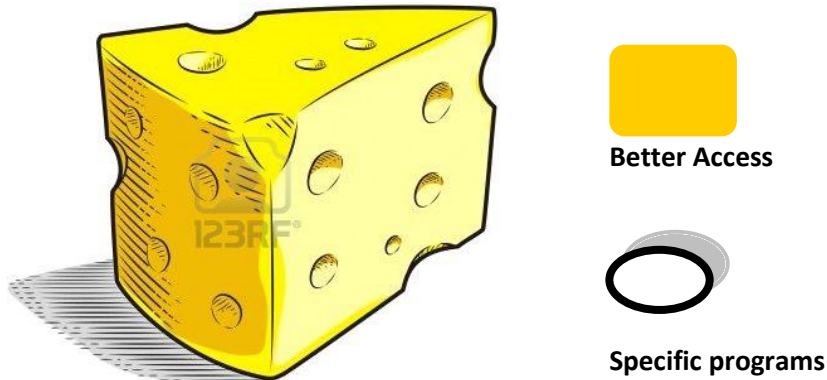
1.1.2 Better Access Provides Universal Access

Access to Treatment

One of the great strengths of the Better Access program is it that **it provides access to evidence-based psychological treatment for anybody with a mental health disorder**. This is in contrast to specific government programs which are restricted to certain age groups, locations, severity, stage of disorder or particular mental health disorders. Universal access helps prevent people from falling

between the cracks because they don't fit into a particular diagnostic/severity/ demographic category.

It is like Swiss cheese where the holes represent specific government programs, and the cheese represents the Better Access program that fills in all the gaps between the holes or the specific programs.



Access to Any Psychologist i.e. choice of psychologist

The Better Access scheme also provides universal access to any psychologist, which allows people to choose the psychologist that has the expertise for their condition, is a good match in terms of personality / treatment mode/demographics as well as location and the times they work. This allows:

- psychologists to develop specialist expertise in particular areas, for example I have particular expertise in working with GLBT clients and those with life threatening illnesses including HIV. Others specialise in treating people with personality disorders, OCD etc .
- clients to be matched with particular psychologists in terms of demographics, ethnicity, cultural knowledge etc. As an important component of therapy is a therapeutic alliance, or the working relationship between the client and the psychologist , it is important that there is a good fit between psychologist and client. Matching is particularly important to some clients, for example it may not be appropriate to refer woman who has been the subject of sexual abuse to a male psychologist. Similarly an older person experiencing a severe bereavement disorder may find it difficult to work with a very young psychologist, or a gay man may find it difficult to see a psychologist who is not familiar with his lifestyle.
- psychologists to adapt their practices to meet the local demands of clients in terms of location and working hours. This flexibility is less present in the public sector where larger centres can mean further travel for some clients (a barrier for clients who do not have cars) or tend to provide services during normal business hours. Working under Better Access I am very happy to work on Saturdays and couple of evenings a week as this frees up part of the day to go to the beach. This allows me to see clients who are working, particularly clients who are at the lower end of the employment hierarchy and do not have the power to take time off during working hours.

These benefits may be harder to achieve in the public sector or under ATAPS when services are provided by a salaried psychologist.

1.1.3 Evidence-based therapy -the recommended number of sessions needed by mental health experts

- **Evidence-based therapy (frequently Cognitive Behavioural Therapy “CBT”) is the internationally recommended treatment for most common mental health disorders either alone or conjunction with medication. Evidence-based therapy is effective and brings about long term change (Barlow, 2001; National Institute of Mental Health) it is not short term sympathy or support**
- **CBT evidence-based practice requires 8 to 20 sessions to treat one uncomplicated disorder**
The following table sets out some estimates from various respected sources of the number of sessions required to treat standard presentations for common mental disorders seen under Better Access.

Disorder	Number of sessions*
Panic disorder and agoraphobia	8-20 ¹
Social phobia	8-20 for uncomplicated disorders ²
OCD	Intensive treatment +ongoing follow up for 12 months ¹
Generalised anxiety disorder	13 - 14 ^{4,6}
PTSD	8-12, 90 minute sessions ⁴
Depression	8-20 or longer term for some ³
Health anxiety	16 ⁶

* after assessment, diagnosis and treatment planning

1 Craske, M. and Barlow, D. (2001)

2. Andrews et al (1994) The treatment of anxiety disorders

3. National Institute for Mental Health <http://www.nimh.nih.gov/health/publications/depression/how-is-depression-detected-and-treated.shtml>

Beck et al(1979) suggest 22 sessions

4. Australian centre for Posttraumatic Mental Health.(2007) Acute stress and Posttraumatic stress disorder-practitioners' guide

5.Barlow, D. ed (2001) Clinical Handbook of Psychological Disorders

6. Wells (1997)

Co morbid disorders are often treated separately or if treated together will need more sessions. In my practice very few clients present with only one disorder (National Institute of Mental Health <http://www.nimh.nih.gov/health/publications/anxiety-disorders/treatment-of-anxiety-disorders.shtml>.)

Other factors such as personality disorders , life stressors, trauma history, or ambivalence about therapy may increase the number of sessions required (see for example Australian centre for Posttraumatic Mental Health.(2007)

1.1.4 Current session numbers

Clients can receive a maximum of 18 sessions of psychological therapy per calendar year, provided as two tranches of six sessions, plus a further six sessions under exceptional circumstances with each lot of six sessions requiring a GP referral. Exceptional circumstances are defined as a significant change in the patient's clinical condition or care circumstances which make it appropriate and necessary to increase the maximum number of services.(MBS Schedule, 2011)

Subsequently clarification was provided to the Australian Psychological Society which indicated inter alia:

Exceptional circumstances are defined as a significant change in a client's clinical condition or care circumstances that make it appropriate and necessary to increase the maximum number of services. Generally, a failure to note an improvement in a client's clinical state itself does not constitute an exceptional circumstance.

.....

An exceptional circumstance can also include clients who have more severe mental illness, where the session limit leads to sub-optimal treatment services. In approving further treatment sessions for exceptional circumstances, the referring medical practitioner should have an expectation that the person would be assisted by a further series of sessions. (Australian Psychological Society website)

The key requirements are that there is a clinical need due to the severity of the condition or other circumstances and perhaps more importantly that there is a clinical expectation of benefit.

18 sessions per annum is not ideal in terms of treatment of complex presentations (see 1.1.3), particularly compared to the 50 sessions available to psychiatrists treating similar clients, nevertheless it has allowed clients with these more complex disorders to obtain effective evidence-based treatment which had not previously been available to them.

Where the number of sessions under Better Access in a calendar year has been insufficient to meet client needs, some psychologists have provided additional free sessions or sessions at a reduced rate or the client has paid, to make up the shortfall. These additional sessions are not picked up in the Medicare statistics. Some clients with more severe or complex conditions have attended for more than one calendar year. In my experience, clients who have attended for more than 18 sessions have nevertheless gone on to achieve good outcomes and no longer require ongoing therapy.

Although the 13-18 sessions are provided under the exceptional circumstances provision, **standard evidence-based therapy often requires this number of sessions to treat one disorder i.e. it is not exceptional for a client to require 13-18 sessions**

The number of sessions available per calendar under Better Access needs to be increased from the existing 18 to provide evidence-based therapy for clients for some clients

1.1.5 Psychological therapy

Therapy is demanding. It is not a cup of tea and some support. Rather, it requires clients to sit opposite a complete stranger, to notice and talk about their innermost thoughts and feeling; to look at ways to change how they view the world and themselves; to try new scary or difficult behaviours including abstinence; to face feared situations including traumatic memories while also experiencing high levels of distress and anxiety and /or the lethargy and hopelessness that comes with depression. Further, a number of clients experience difficulty with trust following childhood or other trauma.

In my experience clients who commit to therapy are highly motivated to use the therapy to help themselves, and spend time reflecting on sessions. When I've asked them to do one task between sessions, they make it two or three. However once therapy is complete, clients in my experience do not wish to keep coming. They are too busy living their changed lives. The recent Better Access evaluation (Pirkis et al, 2011) found that 75% of clients came for 6 sessions or less confirming that clients do not continue with therapy unless they need it (see section 1.1.2).

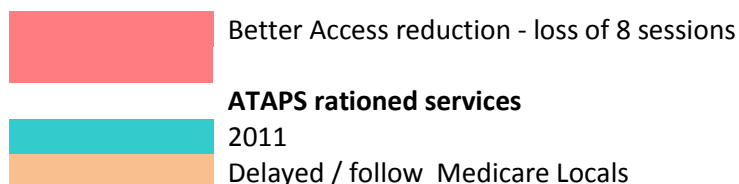
1.2 Changes To Better Access

1.2.1 Budget philosophy

The 2011 budget contained a number of new mental health initiatives that are targeted at specific groups, particularly young people and children, those in remote areas and those with severe mental illness. These services are to be delivered under ATAPS or special funding, predominantly in designated centres. These changes are a move away from the usual Medicare funding model where additional services are incorporated and linked to the Medicare framework. Unlike Medicare services, funding for these services is capped i.e. it is rationed. Further, ATAPS programs targeting the severely mentally ill not be introduced until six months after a Medicare Local is established. At the same time the budget cut back the maximum number of sessions available per annum under Better Access from 18 to 10, reducing the effectiveness of care offered under the universal access scheme for those who cannot access the special programs .Diagram 1 sets out the budget changes. The pink areas represent better access services. The new programs particularly focus on children and younger adults and targeting hard to reach groups.

Diagram 1 Budget changes - illustrating the replacement of Better Access by capped/rationed services

Severe, persistent complex needs			Tier 3 delayed start/ community assistance prog		
			ATAPS short term suicide prevention/delayed start		
Severe	ATAPS New		ATAPS short term suicide prevention/delayed start		
Moderate			EPPIC		ATAPS Outreach
Mild			Head Space ATAPS Outreach		
Preventative	Health check Family mental health service				
	Children		Young adults	Adults	



As part of these changes the government has started to use the terms , mild, moderate, severe and severe and persistent with complex needs associated with different treatment options.

The are some difficulties associated with this non Medicare approach if there is not also a strong universal access scheme to pick up those that do not qualify for the special programs, or who cannot assess them due to capped funding or other constraints such as location/opening hours.

There is also a risk that the different services become fragmented if they are not incorporated under the Medicare framework.

This point is further discussed in section 2.

1.2.2 Mild, moderate and severe mental disorders

Better Access was set up in 2006 to provide access to provide clinical and primary care services for people with mental illness, without any categorisation of mental illness into mild, moderate and severe.

"The package comprehensively addresses current gaps in services for which the Australian Government has responsibility, particularly access to clinical and primary care services for people with mental illness. In this area, the Australian Government will restructure the Medicare Benefits Schedule to improve early detection treatment and management of mental illness through increased access to general practitioners, psychiatrists, and psychologists. Additionally, the Australian Government will provide funding to general practitioners and psychiatrists to employ mental health nurses in their practices to enable a team-based approach to managing people with mental illness, as well as providing more funding for mental health nurses and allied health services in rural and remote areas" (Budget Paper No2 Part 2 Expense Measures Health and Ageing 2006/07)(my underline)

Associated with the proposed changes to Better Access there has been a categorisation of mental illness using the imprecise terms of mild, moderate and severe mental illness.

When using the terms mild, moderate and severe it is important to remember that diagnosed mental disorders, regardless of their severity, cause significant distress and have significant impact on people's lives as is illustrated by the diagnostic criteria below:

- to meet the diagnosis of even mild social phobia a person must meet, inter alia, these criteria
 - *The feared social or performance situations are avoided or else endured with intense anxiety or distress*
 - *The avoidance, anxious anticipation or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning or social activities or relationships, or there is marked distress about having the phobia* (Diagnostic and Statistical Manual of Mental Disorders - DSM-IV-TR, 2000) (my underlining)
- Although most mental health disorders are not classified by severity, there are diagnostic criteria for the severity of depression which provide some calibration of the terms mild, moderate and severe. For example,

An individual with a moderately severe depressive episode will usually have considerable difficulty in continuing with social, work or domestic activities. (The ICD-10 Classification of Mental and Behavioural Disorders, WHO)

That is a client with just one 'moderate' mental disorder is likely to experience a severe impact on their daily lives.

People being treated under Better Access, must meet the diagnostic criteria for mental disorders, that is they are experiencing significant distress and interference with their lives. They are not just experiencing day to day ups and downs, shyness, or some worrying before an important job interview. They are not the "worried well". The adequacy of treatment arrangements need to be

evaluated in the context of the significant impact of mental illness, regardless of whether it is mild or severe.

People with severe mental health disorders will continue to be seen under Better Access despite the change in terminology for the simple reason that there is nowhere else suitable for them to go .
Other than a limited new service ATAPS tier 3 to provide "better coordinated care for people with severe and persistent mental illness who have complex care needs" (Budget paper No 2 , part 2 2011/12) (my underline) and a short term suicide prevention program there is no additional treatment for people with severe mental illness. Also the new programs will be slowly rolled out following the establishment of Medicare locals. Many clients with severe mental illness do not have complex care needs but do need adequate therapy.

Co-morbid disorders and other complicating factors

The diagnostic criteria above refer to individual disorders, however many clients present with two or more co-morbid mental disorders as well as co-morbid physical disorders. They also often are experiencing significant life stress eg divorce, financial problems, housing problems, etc. These other factors increase the impact of mental health disorders on people and increase the treatment required.

1.2.1 Session number cutbacks

Under the budget proposal, the maximum number of sessions available in a calendar year will be cut from 18 to 10. The following diagram shows the distribution of people who saw a psychologist (or other allied health provider) under Better Access, and the effects of the changes. People in the categories above the black line will experience cutbacks.

Section 1.2.3 discusses the characteristics of people affected.

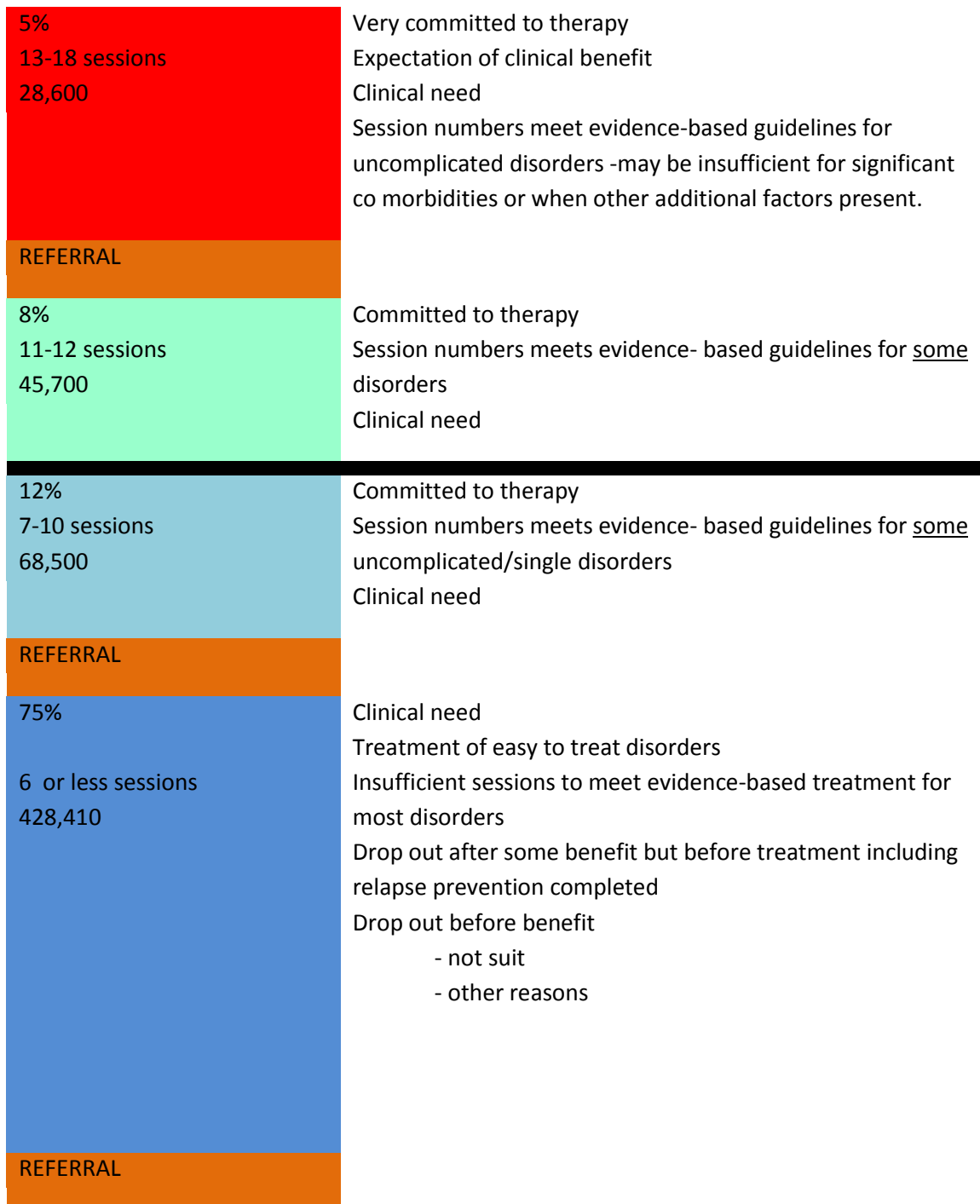
The effects of the cuts are illustrated in Diagram2, based on figures for allied health providers in 2009. The total figure of people affected will be higher as these figures do not include GP provided focussed psychological strategies.

Some 74,000 people who see allied health providers will be affected or 86,000 after allowing for GP focussed psychological strategies¹.

75% of clients only have 6 or less sessions , given that evidence-based practice suggests that in most cases more than 6 sessions is required for treatment that brings about long term benefit , it may suggest that clients are not getting long enough treatment. In the same way that people taking medication may not finish the recommended course .

¹ Total services and some percentage information from Pirkis et al,2011; combined with 13% will be affected (L. Littlefield, Lifematters 21.7.11)

Diagram 2 Showing The Effect Of The Proposed Cuts In Sessions



1.2.2 Key implications of the cuts to session numbers

10 sessions are insufficient to provide evidence-based treatment for many presentations.

- **10 sessions is only 8 treatment sessions, a reduction of 50% from the current program**
Accepted good therapy practice requires at least one session for assessment and at least one final session to address relapse prevention /termination issues, i.e. **10 sessions provide only 8 actual treatment sessions.** This is in contrast to the current program which provides a maximum of 16 treatment sessions (after subtracting 2 sessions) , i.e. the changes represent a reduction of 50% in the number of treatment sessions from the current program.
- **A maximum of 10 sessions is in clear conflict with the recent guidelines for the treatment of Post Traumatic Stress Disorder(PTSD) put out by the government funded Australian Centre for Posttraumatic Mental Health.** They recommend 8-12 90 minute treatment sessions following diagnosis, assessment and treatment planning. They state "where adults have developed PTSD and associated features following exposure to prolonged and/or repeated traumatic events , more time to establish a trusting therapeutic alliance, more attention to teaching emotional regulation skills and a more gradual approach to exposure therapy may be required ." i.e. more sessions may be required. (Australian guidelines for the treatment of adults with ASD and PTSD,2007, p21)

8-20 treatment sessions are needed to provide evidence-based treatment for most disorders and with more required when there are co morbid mental disorders or other complicating factors such as personality disorders, significant life stressors, trauma history etc (see section1.1.3)

For co morbid disorders the proposed 8 treatment sessions represents

- 4 sessions for somebody with 2 disorders (eg social anxiety and depression)
- **2.7 sessions per disorder** for somebody with 3 disorders (eg social anxiety , depression and mild substance abuse); etc. This is clearly inadequate.

A maximum of 10 sessions is inconsistent with other government programs

- **The government recognised that effective evidence-based practice requires more than a few sessions when it provided 12-18 sessions - therapy has not changed since 2006**
Similarly the NSW victims of crime scheme gives 20 sessions and the NSW Workcover also provides extra sessions on review
- **The government currently supports research into evidence-based practice eg CRUFAD anxiety disorders unit and the training of clinical psychologists in evidence-based practice through post graduate degree programs, yet is proposing to not provide sufficient sessions to treat people.**
- **Clients(who are similar to those being seen under Better Access) who see psychiatrists for psychological therapy have up to 50 sessions a year. (Australian Government, Department of Health and Aging: Fact sheet .**

10 sessions has other adverse impacts on clients

Relapses

Clients who have used up their 10 sessions and then later in the same year, experience a relapse or a significant adverse event (e.g. job loss, suicide of a partner, diagnosis of or relapse from a life threatening illness for them or family members, assault etc.) and who require additional sessions for this new event will not be able to obtain them. Under the current scheme, a change in clinical condition would qualify them for further sessions under the exceptional circumstances provision up to a maximum of 18 sessions per year.

Changing psychologists

A good fit between the client and psychologist is essential (see section 1.1.2). Although GP's attempt to match clients with a suitable psychologists, at times it may not be a good match and the client needs to change psychologist for effective therapy. It may take 2-3 sessions to find out that it is working , by which time the client will now have only 7-8 sessions available when starting with a more suitable psychologist. Under the current scheme, changed care arrangements fall under the exceptional circumstances provision with the client obtaining extra sessions to accommodate the need for extra sessions.

1.2.3 Who does this affect?

- **Clients who have completed 10 sessions have gone through a selection process that makes them one of the most effective groups to treat** (they are prequalified in marketing terms)

They have a mental disorder that is treatable by psychological therapy, they have turned up for therapy, they have been committed enough to complete 10 therapy sessions which can be challenging (see section 1.1.5), and there also needs to be an expectation of benefit from further therapy to obtain the additional sessions.

This is in contrast to clients who either do not turn up, drop out after a couple of sessions as they don't like therapy or who drop out after the initial presenting crisis has passed without addressing the underlying disorder(s). Currently 50% of people starting therapy have 5 or less sessions and 75% have 6 or less sessions (Pirkis et al, 2011).

To put the effects of the cut backs in human terms how do I and other psychologists treat:

Please see confidential attachment for clinical examples of the dilemmas that will be faced by psychologists

The cutbacks are already having an effect on clients

It is only 12 weeks to the introduction of the cutbacks on November 1. New clients who are likely to require more than 10 sessions now have a choice :

- come for 12 sessions before November 1 - then manage with no therapy for 2 months until next January

- spread out 10 sessions to the end of the year - i.e. less therapy but no gap

Numbers affected

The number affected is likely to be around 86,000 people per annum (Lifematters , 21.6.11), increasing with the expected increase in the take up of Better Access. This figure compares with

- 772 kidney transplant operations performed in 2009 (McDonald, Excell, & Livingston, 2010)
- approximately 80,000 joint replacements per annum
- death from cardio vascular disease 48,456 (2008) (AIHW, 2011)
- population of Albury 87,500 (2010) (<http://www.alburycity.nsw.gov.au/www/html/790-useful-information.asp>)

Practical implementation issues - effect on numbers

The number of clients who could be expected to require more than 10 sessions at the time of initial referral is considerably greater than the 86,000, as it includes clients that will drop out prior to 10 sessions even though 10 sessions, or more would could provide better treatment for them. If clients were to be diverted to other services on initial presentation at their GP these services would need to manage both the 86,000 and the clients who could be expected to need 10 sessions buy drop out.

For many clients it is not appropriate to refer them on after 10 sessions, as they have developed a working alliance with their psychologist, have committed to therapy and are starting to see benefits. This is particularly true for clients who have experienced childhood trauma. If clients are transferred to other services after 10 sessions ,additional sessions will be required to manage the transition, including at least one termination session and one new assessment session.

1.2.4 What will happen to people who need more than 10 sessions for effective evidence-based therapy?

Clients cannot pay the full cost of therapy

Under Better Access clients are bulk billed or pay a small copayment. Clients on low incomes cannot afford to pay for therapy and even those on higher incomes would find it very difficult to fully fund the number of sessions for effective treatment, particularly if a triggering event has been unemployment, severe family illness or divorce. My experience is that my clients have either not previously received therapy due to cost or they have had some short term non evidence-based therapy from a less qualified provider. Pirkis et al (2011) found that Better Access was reaching new clients.

There are no reasonable, affordable alternatives for people requiring more than 10 sessions

The government has suggested a number of alternatives for 86,000 people per annum who will require more than 10 sessions of psychological therapy but these are not adequate for the numbers of clients involved. Better Access was introduced in 2006 to cater for those who could not obtain adequate therapy from other services, if clients could not obtain therapy then, they will not be able to obtain it now.

Despite most of the suggested services currently operating, GP's are choosing to refer clients under Better Access. This suggests that in the GP's view Better Access is the most suitable treatment or that clients cannot access other services.

Specifically:-

- **State-based mental health services** -continue to have limited capacity, and frequently focus on people with psychosis or other very severe disorders. My experience is that the adult clients I'm seeing, aged 40 and 50 have not previously been able to access mental state-based mental health care and so are unlikely to do so now.

Currently **two state based mental health services refer clients to me**, either because I have the specialist expertise they do not have or because the client has run out state based sessions but need more clinically.

- **Private psychiatric services** –do not have significant additional capacity as shown by the client waiting lists . To put the demands in perspective the following table shows the number of additional psychiatrists and increased costs to Medicare under two scenarios.

	Additional Psychiatrists req.	Total psychiatrist cost \$m	Additional cost of transfer*
Transfer after 10 sessions²	468	67.82	42.69
Initial referral to psychiatrist	1215	171.2	60.4

* Compared to treatment as usual by psychologists
See footnote for calculations and assumptions.

Around 470 additional psychiatrists would be required to cater for 86,000 clients (assuming they transfer after 10 sessions and need additional sessions to restart the therapy elsewhere) . This is also a more expensive option for the government than funding therapy under Better Access ,with the additional cost to the government of funding psychiatrist sessions would be \$43million. Further psychiatrists typically charge significant copayments for ongoing therapy making it inaccessible for many clients. (Pirkis et al (2011) p24)

²Assume clients have a an average of 3 extra sessions above 10 , and 2 additional sessions to handle the transfer.

Assume psychiatrists see 20 clients a week for 46 weeks per year.

Psychiatrist cost per 50 minute session 187.85 (session 1) 150.20 subsequent sessions

Weighted average cost of psychologist sessions \$94.33 (2009) (Pirkis et al,2011), inflate 5% to \$99.05 current dollars

Transfer after 10 sessions: Psychiatrist on average sees client for 5 sessions (including additional sessions to manage transition)

Number needed = $86,000 \times 5 / (20 \times 46) = 468$

Cost of psychiatrist treatment = $86,000 \times (187.85 + 4 \times 150.20) = \67.82 m

Cost of psychologist continuing with treatment = $86,000 \times 3 \times 99.05 = \$m25.55$

See Psychiatrist from start

Number needed = $86,000 \times 13 / (20 \times 6) = 1215$

Cost of psychiatric treatment = $86,000 \times (187.85 + 12 \times 150.20) = \171.2 m

Cost of psychologist treatment = $86,000 \times 13 \times 99.05 = \110.7 m

- **tier 1** – increased funding is being directed at increasing the reach of primary mental health care rather than picking up existing clients. (Roxon, Macklin, Butler, 2011). It is also unclear whether ATAPS tier 1 will continue to provide up to 18 sessions per calendar year, if it does, it is likely to be quickly overwhelmed by GP referrals for clients that are anticipated to require more than 10 sessions.
- **tier 3** – this service is only available to those with severe and persistent mental health problems who have complex needs and is directed at a limited number of clients (24,000) (Roxon, Macklin, Butler, 2011). Further this service will not be operational until six months after a Medicare local is set up in a particular area so that tier 3 commences 18 months after the cut backs to Better Access sessions in some areas.
- **ATAPS suicide prevention service** – this is a short term intensive service and not designed to replace longer term therapy. As for tier 3 it will not be introduced until after a Medicare local has been established.

A significant and odd gap in treatment

Changes to the Better Access scheme mean that we will have the odd situation where people with short term mental health disorders or easily treated disorders will receive effective psychological treatment with 10 sessions available to them, and eventually those with serious and persistent mental illness with complex needs will be catered for but not those clients in the middle Tier 3- delayed start

The only cost of keeping a maximum of 18 sessions is the cost of the sessions of the people who use it. If more suitable services are available elsewhere then the GP will refer clients to it, and there will be no cost to Better Access. Only if Better Access is more suitable will clients be referred to it and the Better Access program incur a cost.

1.2.5 Economic Considerations

Given current financial constraints it is important to ensure that health care dollars are wisely spent having regard to the cost of service and the full range of benefits from a service.

Provision of effective treatment to Better Access clients appears to be a good financial investment

The maximum cost of providing the cutback 8 sessions per year to a client is \$958 for clinical psychologists and \$754 using the weighted average cost across allied health providers in Pirkis et al(2011). The cost will be lower where the client has less than 18 sessions.

This is offset by savings in recurrent costs as clients experience improvements in their mental health

- Reduced doctors visits /ED and crisis team visits
- **Reduced centrelink payments (Newstart pays \$237 per week i.e. cost of extra clinical psychology sessions is equivalent to just 4 weeks centrelink payments in one year)**
- Reduced future Better Access use
- Indirect effects from increased productivity where people have less time off and are more able to concentrate on their work³
plus
- Increased tax paid to the federal government from clients moving into work or moving into better paid work (a common outcome)
- Improved physical health reducing the long term cost of illness⁴

Better Access services are cheaper than other alternatives:

ATAPS is expensive compared to Better Access

ATAPS is expensive compared to Better Access (L. Littlefield, Lifematters, 12.6.11) .

With budget constraints it does not make sense to provide services through ATAPS in situations where Better Access is achieving acceptable results, the more expensive ATAPS service should only be provided when there is a demonstrable need for example in outreach services, or for clients with severe and persistent mental illness with complex needs .

The costs of providing therapy under a Better Access model are comparable to the costs of providing public sector services.

In NSW the cost per therapy session provided by a clinical psychologist with 5 years experience in the public sector is about \$140⁵ per session compared to the Medicare rebate of \$119.20 ,after taking into account the costs of administration, late cancellations, supervision, etc. borne by the public sector.

Clinical Psychology services are similar to those provided by psychiatrists but are 25% cheaper⁶

³ For example recent research has shown that 55% of people who suffered stress or other mental conditions were absent from work for five days or more (ABS *Australian Social Trends, June 2011* reported in SMH)

⁴ For example depression is a risk factor for cardio vascular disease both directly and because it acts as a barrier to the adoption of healthy lifestyles including exercise and not smoking. AIHW 2011. Cardiovascular disease: Australian facts 2011

⁵ Salary of a clinical psychologist with 5 years experience including leave loading \$97,920
On costs (accommodation, equipment, admin, management etc.) 30% \$29,736
Total cost **\$127,296**

Assume see 20 clients a week for 46 weeks after (no shows/ late cancellations) - from discussion with colleagues

Cost per session = 127,296/20x46 = \$138 per session or \$140 per session after allowing for sick and FACS leave.

⁶ Medicare rebate for clinical psychologists \$119.80, for psychiatrists \$150.20

1.2.6 Comments on government rationale and criticisms of the Better Access program

Announcing the budget mental health changes the government made a number of comments about the cut back to Better Access (Media release : Delivering National Mental Health Reform). Key comments are discussed below.

“ many of the most disadvantaged Australians are still not accessing the services they need” and that it is appropriate to redirect funds to those most in need.

This statement appears to confuse disadvantage with need for mental health care.

- **Mental health disorders, in the same way as physical illness, occur across all income groups** as illustrated by the tragic suicides of Rene Rivkin and more recently Charmaine Dragun. ' Depression occurs in persons of all genders, ages, and backgrounds' (WHO, 2011). The ABS reports that 11% of people in the least disadvantaged quintile and approximately one in ten in the median quintile had a mental or behavioural problem. Although the equivalent figure is higher (16%) for the most disadvantaged quintile, the majority of mental and behavioural problems occur in areas other than the most socio disadvantaged area. People in all areas require access to effective mental health care. I see people with of disabling mental health disorders across all income groups, who require, and significantly benefit from, evidence-based treatment.
- **There is no indication that people in higher socio economic groups are being over serviced and receiving mental health care that they do not need.** Using the details from the Pirkis evaluation (2011) it appears that those in the highest socio economic group have an average of 4.6 sessions versus those in the lowest socio-economic group having an average of 3.7 sessions per annum, compared to the maximum available of 18. This does not suggest that clients in the highest quintile are being over serviced. The same report also estimated that following the introduction of Better Access only 46.1% of mental health care needs were being met in Australia, which suggests that even in the higher socioeconomic group there is still a long way to go before there is overservicing
- **Relative socio-economic advantage does not directly translate into the ability to pay** as people paying high rents or high mortgages may not be able to pay for unexpected mental health care costs, particularly if these occur at the same time as other unexpected events such as job loss or physical illness. Further socioeconomic groupings as the ABS (2010) warns 'are assigned to areas and not individuals..... When area level indexes are used as proxy measures of individual level socio-economic status, many people are likely to be misclassified'. This suggests that even in the most socially advantaged area there will be individuals who are strongly socially disadvantage. This agrees with my personal experience, I bulk bill a number of clients living in very wealthy suburbs due to financial need. A young person living in share house (with frequent moving costs, rent increases), working in a casual and insecure hospitality job , without family locally, can experience more life stressors than a person the disability support pension living in public

Percentage difference = $(150.20 - 119.80) \times 100 / 119.80 = 25\%$

housing. The strength of Better Access is that it is available to all Australians, and does not depend on the characteristics of their geographical area, it stops people from missing out.

- The government is concerned that there is less use of Better Access in the most socially The cut backs will also penalise the people in the lowest socio economic groups that currently use and benefit from Better Access

- Much is made about the cost of directing services to more disadvantaged areas. But these costs include treatment costs that would have been incurred had the client been treated under Better Access - treatment costs are not additional costs and should not be included in the costs of new programs. One could argue that the government has saved money from the historical lower uptake of Better Access in these areas , and could now use these savings to target harder to reach groups.

- Using education as an example - we do not teach children to read from higher socioeconomic areas, even though we know school attendance in some other areas is very low. Australia recognises the importance of learning to read , and provides resources for all , and allocates additional funding address low school attendance.

- By cutting services to those people that require more than 10 session for effective treatment(in line with standard evidence-based therapy) the government appears to be actually penalising those in the lowest socioeconomic group that currently access and benefit from Better Access. In 2009 , 150,000 people from the lowest socioeconomic quintile accessed Better Access and 78% were bulk billed.

Other Equity considerations

Although the government has used socioeconomic disadvantage to justify the redistribution of health care dollars , there are other broader equity considerations that also need to be considered when allocating health care dollars.

- **The people I see in their 40s and 50s appear to have missed out yet again.**
 - they be did not receive adequate protection as children from childhood trauma (including violent and sexually abusive parents)
 - they did not receive protection from bullying at school (for my gay clients this was often very severe)
 - they did not receive early intervention programs, child mental health care or youth oriented programs such as Headspace
 - and they were unable to access mental health care because of costs until now.,Yet the government is proposing to cut access to effective mental health care for this group.

Many of the new programs are early intervention programs targetted at young people (see diagram 1, section 1.2.1), that have been funded by cut backs to needed, effective mental adult health care. This is the equivalent of funding quit smoking programs by reducing treatment of people with cancer or COPD from smoking.

- There continue to be **significant inequities between the treatment of people with physical disorders and those with mental disorders** even though the burden of disease to those with mental health disorders may be considerably greater than those with physical health disorders.

There is no restriction on physical health care , GP visits are unlimited, and although there are specialist waiting lists, the latest in physical health care is universally available.

Comparing a 50 year old man with an arthritic hip with 50 year old man with a disabling anxiety disorder.

The man with the arthritic hip , has mobility limitations and experiences some pain. But he can continue to enjoy friends and family, go out to most places, go on holiday etc. In contrast the man with severe anxiety may find it very difficult to talk to people, go out alone, feel anxious in crowds and incessantly worry . His anxiety may stop him from working and may have affected his life for many years.

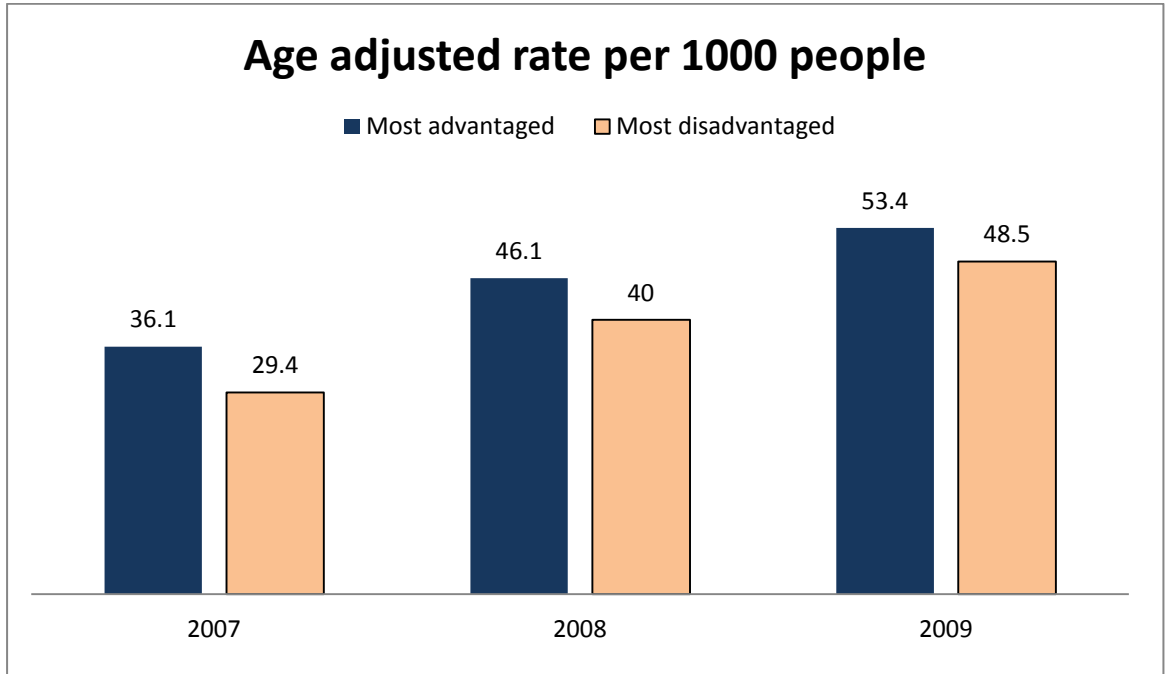
The man with the arthritic hip will receive good treatment in about a year , with the proposed Better Access changes the man with anxiety will not receive evidence-based treatment, even though he is much cheaper to treat

- There is considerable inequity between the **sessions available to clients who see psychiatrists and get 50 sessions a year and clients of clinical psychologists who will only get 10 sessions a year, even though the psychological treatment and need may be identical.** (Psychiatrists also prescribe medication but do not need 50 sessions a year to do so)

Better Access and social economic disadvantage

The following table shows who has been getting Better Access services by comparing the average age adjusted⁷ rate across the most advantaged and most disadvantaged quintiles based on figures from the recent evaluation of the better access program (Pirkis et al, 2011).

Diagram 3



Although there are more age adjusted services provided to those in the most socio economic advantaged areas the gap between the number of age adjusted services provided

⁷ Age adjusted figures "remove the effects of the different age structure of the two groups you are comparing". Standardisation,]. Cancer council

to the most advantaged in the least advantaged **has halved over the three years from 23% to 10%**⁸ - that gap is closing. Further the service is provided to the most disadvantage in 2009 is greater than those provided to the most advantaged in 2008.

There is more disparity in the total number of services provided across quintiles of socioeconomic disadvantage (i.e. 27% is in the lowest quintile and 13% in the highest), but these figures are because there is a greater proportion of children in areas of lower socioeconomic disadvantage and children generally have considerably lower rates of services under Better Access. Children have lower rates of treatment partly because children have considerably lower rates of mental disorders.

There are still clear disparities in treatment provided under Better Access for children and also for those in remote areas and certainly it is appropriate to introduce targeted programs for these groups , but not at the cost of effective and needed services provided to others under Better Access.

"..the vast majority of patients receiving allied health treatment through the Better Access program receive between one and ten allied health services each year"

The government seems to adopt the view that an average of all treatment patterns provides the best indicator of appropriate treatment for all individuals rather than basing treatment on evidence-based research conducted over many years i.e. average treatment patterns are not a good indicator of appropriate treatment

- In my experience there are a number of different reasons why people receive 10 or less sessions, they may have transient or easily treatable, less complex disorders, they may not like therapy or find it helpful, particularly as therapy is not a quick fix, or they may come until they start to feel a bit better but do not at the time wish to address the underlying issues to that would lead to a long term improvement in their mental health . It is therefore not appropriate to select the number of treatment sessions provided based on the average used.
- To use a physical health example, people with a sore leg may go to the doctor and will receive different complexity of treatment depending on whether they have just pulled a muscle, broken a bone or have bone cancer yet although the vast majority will only require relatively short term simple treatments, we do not use this as a rationale to not effectively treat those with bone cancer.
- Patient compliance is often low but we do not develop medication treatment protocols based on the average use of medication which in would include the low compliers , instead we refer to evidence-based practice.
- The vast majority of GP consultations are Level A or B , with long and special consultations being about 15% of all consultations, and long consultations about 10% i.e. similar rates to the 13% requiring more than 10 sessions under better Access. In this case the government is

⁸ eg((53.4-48.5)/48.5) x 100%

looking at ways to encourage longer consultations rather than dispense with them because they are relatively small proportion of total consultations. REF

Other Criticisms In The Media Of The Better Access Service

There has been criticism that the bulk billing rate of psychologists is lower than that for GPs, although it appears to be higher than psychiatrists (Lifematters 21.7.11)

The Medicare rebate is only 85% of the scheduled fee for psychologists, but rebate to GP's is 100%. From 2009 figures (Pirkis et al, 2011, page 24) although a copayment of \$32.15 was paid for 65.4% of services provided by clinical psychologists this is only \$11.60 above the scheduled fee. Across all payments, Clinical Psychologists charged only an average of 49 cents⁹ above the scheduled fee compared to the equivalent figure for GP's of \$1.48.¹⁰ Compared to GP's, clinical psychologists are providing bulk bill services at a discount and effectively recouping this through copayments from clients who do pay.

As a practicing clinical psychologist, if the government does not want the scheduled fee to be charged i.e. a copayment, I wonder why they specify it in the MBS schedule, as I assume it is there as a guide.

- Middle class welfare: There has been criticism in the press that Better Access is Middle class welfare (SMH 15.7.2011 Lifematters). My experience is that more socially advantaged clients often experience (unnecessary) shame about their need for therapy and inability to manage a diagnosed mental disorder by themselves. They can have strong beliefs "I should manage this myself", "All it takes is willpower" etc. In my experience these beliefs make it difficult to engage clients for more than the time that they need to start to slightly better, it appears that they don't continue with needed therapy because of shame. This is particularly a problem when clients have depression which can increase feelings of guilt and low self worth.

It is important that the committee makes it clear that mental illness like any illness can happen to anybody and affirm the right of socially advantaged clients to treatment.

1.2.7 Other effects of the cutbacks in the number as Better Access sessions

⁹ Service data from Pirkis et al (2011) p24

For clinical psychologists

Percentage of services bulk billed = 34.6%, with copayment 65.4%

Medicare rebate 2009 for services provided by Clinical psychologists $\$(115.05 + 117.60)/2 = 116.32$

Scheduled fee = $116.32/0.85 = 136.85$ Rebate is $136.85 - 116.32 = \$20.53$ below the scheduled fee

Average cost across all Clinical psychologist services = $.346 \times 116.32$ (bulk billed) + $.654 \times (116.32 + 32.15)$ (with copayment) = \$137.35

Difference scheduled fee and average charge = $137.35 - 136.85 = \$0.49$

¹⁰ GP's percentage of services with copayment 7.3%

Copayment \$20.26

average copayment = $20.26 \times 0.073 = \$1.48$

- We already have a problem in encouraging people to seek help for mental health problems due to stigma and people's belief that they should be able to manage anxiety and depression by themselves – if somebody does not recover in the government provided 10 sessions there is a risk that they will blame themselves for still having a problem, and will also tell themselves that they tried therapy and it didn't work
- treatment in 10 sessions, trivialises the effect of mental health
- **loss of intellectual capital** – a number of clinical psychologists including myself have undertaken significant additional training (here or overseas) to allow us to work with the specific client groups that we see under Better Access. With a cut back to 10 sessions it will no longer be possible to effectively use the skills gained, a loss to the Australian public.
- **Burnout** – trying to treat clients seen under Better Access with a maximum of 10 sessions will place very high levels of stress on committed psychologists. I am concerned about how psychologists will cope with daily seeing people with whom we can only provide Band-Aid or palliative care, when knowing that they will continue to suffer a considerable burden of mental health disorders and knowing also that we have the skills to help, but that the government will not fund treatment .
- Clinical psychologist in particular are a highly skilled group, and it may be that over time the frustration of working within a very inadequate framework of sessions will lead to clinical psychologists moving into other roles or out of the profession.

2. The impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program;

2.1 Current ATAPS services

ATAPS is an outreach service targetting hard to reach groups Tier 1 , and also runs a few specialist programs under Tier 2. It will also run a number of the new budget measures.

My experience has been with ATAPS tier 1 in an area where ATAPS acts as a broker and pays psychologists in much the same way as Medicare does. I provide services both under ATAPS tier 1 and bulk bill, depending on how the GP makes the referral.

ATAPS is not necessarily free to the client, as under ATAPS am allowed to charge up to \$30 as a copayment , which is only marginally less than the average copayment charged by clinical psychologists of \$32.15 (Pirkis et al, 2011, page 24). In contrast when I bulk bill I am not allowed to charge a copayment.

There is no shortage of bulk billing psychologists in my area - although it is widely known I bulk bill I am not overwhelmed with bulk billing referrals as I would be if there were a shortage, and I regularly see clients from 5 different electorates, including areas of high public housing. Also I rarely get a request to bulk bill somebody outside my usual criteria.

It would be simpler and cheaper in my area to use ATAPS as an outreach referral service to bring in people to the Better Access scheme and avoid the costs of a duplicate, less efficient system.

2.2 ATAPS and team based services

Comments in the media have suggested ATAPS is better in that it provides a team based service, where clients get access to broader care (Lifematters , 21.6.11).

Team based care may be helpful for some clients with complex or other special needs.

However my experience is that most of the clients I see under Better Access do not need a team-based approach they just need good therapy and sufficient sessions for evidence-based practice (this is similar to my experience when I worked in an excellent multidisciplinary Centre in the public sector where most clients did not need other services). They already have a GP and when needed a psychiatrist. There are some people for whom a team-based approach would be preferable but my experience they are not majority of those who present under Better Access, and they are certainly not the clients who do complete 10 services as they tend to drop out and find it difficult to make regular appointments.

In a budget situation where there are limited financial resources, it is important that we provide the most cost efficient services to clients that at the same time meet their needs in terms of treatment and availability. As a team-based approach is more expensive it is important that we only provide this to clients who it and continue to provide therapy only services (with the option of consulting other healthcare professionals if required) to those clients for whom this provides adequate service.

In my experience GP's are skilled at selecting the most suitable service for clients.

2.3 Disadvantages of area based services

The disadvantage of the ATAPS service is that it is area based (whether it is provided through salaried psychologists or through brokering services).

This reduces access to psychologists with specialist expertise who currently service several local areas and makes it more difficult to obtain a good fit between psychologist and client.

Medicare local areas do not follow the boundaries of local communities with common characteristics and who would be best served by psychologists with expertise in working with these communities. A psychologist with particular expertise working with a particular community may only be able to be seen by half the community if the other half is in a different Medicare Local area.

Whatever ATAPS delivery methods is used, it's going to be important that there is a mechanism to allow people to access ATAPS outside the local area to be able to access particular expertise and fit with the psychologist.

2.4 Ensuring ATAPS has the relevant expertise

It will be important with the increasing focus on ATAPS services that ATAPS is able to engage the services of experienced clinical psychologists, particularly for the treatment of those with severe and persistent mental illness. Where ATAPS services are provided by salaried employees it is important that there is a career path for these employees rather than being seen as a starting job the new graduates.

2.5 ATAPS is capped funding

ATAPS services are capped , which leads to a rationing of services . This compares to Better Access which provides access to all who need it. My experience is that ATAPS funding tends to run out leading to temporarily discontinued services . Moving treatment to capped ATAPS services is a significant shift away from the Medicare ethos of providing universal access to needed health care.

3. Services available for people with severe mental illness and the coordination of those services;

Services available for people with severe mental illness

My current experience is with Better Access. As discussed elsewhere, for many clients with severe mental illness Better Access works well provided there are enough therapy sessions available. Where Better Access is not suitable, in my experience GPs are excellent at choosing the best care available.

GPs

My experience is that my local GPs are keen to obtain the best care for those with severe mental illness, they do take the time to discuss clients, listen to comments and reflect on and think about what is best for the client. They refer clients to psychiatrists and other health professionals including the crisis team when needed. Yesterday, I was rung at 7:45 AM by a local GP who wanted to discuss her concerns about one of my clients who she was about to see later that morning. It would have been simple for her to just give him another referral but she wanted to discuss his progress and to look at whether there was anything else she/we could do. This is typical of local GP involvement in coordinating the best broad mental health care for clients.

Many of my clients also have severe physical illnesses which impact on their mental health and it is essential to liaise with GPs about this.

It is also my experience that a **number of my clients also already have access to social workers** and case managers from other services including transitional housing, specific community and physical illness groups, crises teams and child services.

Nevertheless I would find it helpful to have telephone access to a social worker, who could also see clients if required.

In summary GP's work best for me as coordinators as they are across all the client's needs.

4. Other possible sources of savings

Alternative other savings are:

- **Remove the requirement for a mental health care plan** to be completed before a referral can be made and introduce a separate Medicare item for ongoing mental health care management for those who actually need it.

Patients referred to other specialists, including psychiatrists, can be referred using a simple referral letter, often in a Level B consultation if the GP is already in regular contact with the patient. Even the best mental health care plans are predominantly a few pages of assessment, but the assessment, is as is the case with all specialists, is redone by the psychologist. Client management can be done in the same way as GP's manage other physical illnesses and tends to proceed over time.

Potential savings will result in removing the premium for mental health care plans prepared by GP's with mental health training (from \$18.27-\$26.88 per health plan) and from possible shorter consultations eg Level B vs. Level C \$32.75.

Potential savings are around \$8.6¹¹ Some of these savings will be offset by a new item for complex management of mental disorders.

- Remove the need for subsequent referrals and a mental health review, but keep the requirement for the psychologist to send a letter after each tranche of 6 sessions and on termination of treatment. GPs tell me that they routinely assess mental health and the treatment provided by the psychologist at every GP encounter. For clients who do need further management and review this can be accomplished through a new mental health care plan framework that is tailored to these clients.

Potential savings (assuming that the current scheme is retained) \$20m¹²

- **Reduction in ATAPS Tier 1 funding** in areas that have adequate levels of bulk billing, as this does not appear to add to the options for client healthcare. (See section 2.1)
- **Reduce payments made to GPs for focussed psychological strategies**
Currently GP who has undertaken 3 days mental health training receives \$125.20 for a 40 minute session compared to the Level D payment of \$99.55, i.e. an increase of 25% which is high when the GP had 8+ years of training to be able to earn the basic level D payment. The GP payment for 40 minutes of focussed psychological strategies is equivalent to \$156.50 for a 50 minute session. This compares to \$119.50 received by a clinical psychologist who is a specialist provider of psychological therapy.

5. The two-tiered Medicare rebate system for psychologists

5.1 Differences between Clinical Psychologists and other psychologists

Clinical psychologists are specialists in the assessment, diagnosis and treatment of psychological problems and mental illness. (Australian Psychological Society, <http://www.groups.psychology.org.au/cclin/>). Clinical Psychology has been seen as a separate , specialty for over 50 years with the Journal of Clinical Psychology (a US journal) first published in 1945 and the Australian Psychological Society starting to publish the Clinical Psychologist in 1996 (Sydney University Library catalogue).

Clinical Psychologists can be compared with other psychologists who work and have training in other areas

¹¹ Assume number of mental health care plans is number of clients seeing allied health practitioners- 571,000 in 2009 (Pirkis et al , 2011, page 23).

Assume average saving of \$15 per client

saving =15x 571,000= \$8.6m . In practice not all patients with mental health plans will go and see an allied health practitioner

¹² 2009 figures see diagram 2 section 1.2.1.

Number having more than 6 sessions 142,800 and assumed mental health review \$108.90 , savings = \$15.5m

Number having review after 12 sessions, 28,600 and assume LevelB consultation \$34.90, savings = \$4.5m

Despite popular belief, most psychologists do not work mainly with people who are mentally ill. The majority help mentally healthy people find ways of functioning better, for example, training people to handle stress in the workplace (Australian Psychological Society, <http://www.psychology.org.au/study/careers/>

Comparison of clinical psychologists with general psychologists

(see next section for discussion of other specialist psychologists)

General psychologists complete a four-year general psychology degree (which does not include a practical component) as do all psychologists and then a two-year registration process.

The difference between a clinical psychologist and a general psychologist is well defined New South Wales award for psychologists, as set out in the following table.

Table 1: Extract from the NSW award covering psychologists in health and community

Clinical Psychologists ¹³	General Psychologists
<p><u>Characteristics</u> (a) Task Clinical Psychologists are trained in the scientific study and application of psychological knowledge and principles for the purpose of diagnosing, understanding, preventing, treating and advising on psychopathological distress or dysfunction and to promote subjective well being. The essential tasks of Clinical Psychologists are assessment, diagnosis, case formulation and treatment of psychopathology as it is manifested (variously) in cognitive, emotional, motivational, personality and behavioural disturbances in adults, adolescents or children across a range of health care settings including outpatient, community, primary care and in-patient facilities. Referrals appropriate to Clinical Psychologists encompass a diversity of presentations – from acute to enduring and mild to severe. Problems range from those with mainly biological causation to those emanating mainly from psychosocial factors, as well as problems of coping or adaptation to adverse circumstances that are not themselves reversible by psychological intervention eg physical disability, physical illness, bereavement. (b) Judgement and Problem Solving Clinical Psychologists exercise independent</p>	<p><u>Characteristics</u> (a) Tasks Psychologists are trained in the independent application of existing treatment techniques and assessment procedures to a range of behavioural and emotional disorders. Psychologists facilitate change in attitudes and behaviour related to health and illness, for the purpose of preventing and relieving distress or dysfunction and to promote subjective well-being and personal development. (b) Judgement and Problem Solving Psychologists evaluate psychological factors affecting maladaptive behaviour and provide individual counselling services, therapeutic interventions, group programs and case management in the areas of (but not limited to) anger management, parenting skills, stress management, social skills training, assertiveness</p>

¹³ The Clinical Psychologist is a fully registered psychologist with a Masters degree or higher in Clinical Psychology, Clinical Neuropsychology or some other recognised clinical area in psychology that the employer deems relevant to the functions of the position. (my underline). I.e. other specialties are covered by the award here their specialty is relevant to the position only

<p>judgment concerning the selection and application of principles, methods and techniques of psychological assessment and/or treatment. Chosen interventions involve the adaptive utilisation of empirically-derived psychological principles.</p> <p>(c) Supervision and Independence The appropriate discharge of duties and demonstration of competence at this level is in consequence of an understanding of theories and techniques, which enable Clinical Psychologists to assess and diagnose psychological problems and disorders and design and implement appropriate psychological procedures. Clinical Psychologists work independently and receive clinical supervision from another Clinical Psychologist. Initially such supervision is provided by a more senior and experienced professional colleague but after several years experience, Clinical Psychologists may participate in peer supervision only.</p>	<p>training, mental health and problem addictions. Psychologists undertake psychometric testing eg intelligence, personality and vocational, consistent with NSW Psychologists' Registration Board competencies.</p> <p>Supervision and Independence</p> <p>Psychologists may work independently with clinical supervision from a more senior Psychologist.</p>
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Health and community employees psychologists (state) award. Industrial relations commission of New South Wales 5.3.2009

Difference between the training of Clinical and general psychologists

A clinical psychologist has done a demanding specialised two year Masters or three year Doctorate degree followed by two years supervised practice, whilst a general psychologists have a four year theoretical degree + two years supervision .

I have completed both the general psychologist registration process and the clinical masters followed by 2 years supervision - my experiences are detailed below.

Honours degree + supervised practice registration process

I started by registration process in 2000. At the time starting the process I had a first-class honours degree, an excellent foundation in understanding psychology of predominantly normal people. I had had one semester in my third year in abnormal psychology i.e. mental health disorders and had also completed an excellent ethics course. At the time I was then required to complete two years registration process working the equivalent of around 16 hours a week (averaged over two years) in some form of psychological endeavour. I completed several months in a private organisational psychology firm, spent time doing phone counselling and then worked one day a week with a private company that provided mentoring and coaching services to clients. I also had the required 80 hours of supervision. At the end of the process although I could do some things well (and I thank my supervisors) but I did not have a good foundational comprehensive knowledge of one area of practice. Under Medicare requirements provided I obtain some CBT training (currently the APS is

running a 10 hour online course) I would be eligible for Medicare funding. Although there is an ethical requirement that a psychologist should not practice outside their area of expertise, the greatest difficulty is you don't know what you don't know. I had done phone counselling was pretty good at it, but had no idea about example specific treatment for people with severe trauma. Although the requirements of the registration process have been tightened the fact that I was able to go through and obtain registration this way less than 10 years ago suggests that many of the people who are in fact working as general psychologists would have had similar or less training.

Clinical Masters +2 years supervised practice

My own experience of the training was that it gave me a strong theoretical basis for assessment, diagnosis and treatment based on access to current research articles but the most important part of the training was the complementary depth of practical experience that I gained both in the university clinic and on placements. By the time finished I had treated over 40 clients with over 18 different mental health disorders (including personality disorders) under the supervision of nine different clinical psychologists each who had a strong interest in helping me develop my skills. In addition I had conducted detailed neuropsychological and other assessments on seven clients with different disorders. I had seen clients who ranged in age from 3 to 75, clients from seven different CALD groups, clients with physical and cognitive impairments in addition to the mental health disorders, and worked with an interpreter. I had also completed a thesis that required me to spend five hours each with 25 people who had acquired brain injuries which helped develop an understanding of the practical effects of living with a brain injury or other disabilities. I believe that the effect of this intensive and broad exposure to clinical psychology provided me with an excellent foundation. I also had solid experience in various multidisciplinary environments. The course was an immersion in Clinical Psychology for two year, similar to a language immersion course. In my first job where I undertook my supervised practice, because of my excellent training at university I was able to quickly take on complex clients and benefit from the individual and peer group supervision I received in relation to the treatment of these clients. Supervision in these two years did not teach me how to do basic clinical psychology(as my masters has already given me this) but helped me refine and extend my skills.

Perhaps the most important aspect of the course was that by giving me this is a broad exposure I now have the foundation to develop skills in any particular area if required and also have a much greater sense of what I know what I don't know.

I do not believe that anything less than a rigorous formal course and complementary practical training would have given me the skills to deal with the complex cases that I now see daily and obtain good results with.

In my view there was a clear difference in terms of theoretical knowledge and practical breadth practical experience between clinical psychologists and psychologists undertaking the general registration process.

The tail end of the registration process coincided with the start of my Master's degree. Despite having almost completed my generalist registration and having attended 3 days of general CBT skills training at the start of my Masters, I failed the clinical skills test that we sat prior to being allowed to start to practice under supervision in the university clinic - and had to spend an afternoon with a

helpful lecturer to get my skills my clinical skills up to scratch. This to me, this illustrates the difference in standards between a general psychologist and a clinical psychologist.

A similar situation exists in business where traditionally managers have learnt how to manage on-the-job, but over the last 20 years the MBA has become required training for senior managers.

Comparison of Clinical Psychologists with other specialist psychologists

The following table (taken from the Australian Psychological Society website (Australian Psychological Society, <http://www.psychology.org.au/study/careers/>), compares Clinical Psychologists with other psychological specialties , and clearly illustrates that only clinical psychologists specialise in treating mental illness.

Clinical psychologists	diagnose, treat and prevent a wide range of mental and physical health issues
Counselling psychologists	help individuals and groups with personal wellbeing, relationships, work, recreation, health and crisis management.
Clinical neuropsychologists	assess and manage individuals with brain impairments
Community psychologists	help people achieve their goals in areas such as welfare and community projects.
Educational and developmental psychologists	provide children and adults with assessment, intervention and counselling services for learning and developmental issues across the life span.
Forensic psychologists	work with police, the law and legal processes, and in correctional services.
Health psychologists	promote the prevention and treatment of illness and may work within the health care system.
Organisational psychologists	specialise in the areas of work, human resource management, training and development, and market research and advertising.
Sport psychologists	help people involved in sport and exercise maximise their performance, enjoyment and participation.

Although specialist psychologists have also undertaken post graduate training it is in a different area to clinical psychologists - they have chosen not to specialise in mental health but in other areas. They do not have the clinical expertise of clinical psychologists.

5.2 Do clinical psychologists bring additional benefit in to clients seen under Better Access compared to generalist psychologists

Clients seen under the Better Access program are similar to those seen in other settings in terms of severity (Pirkis et al, 2011). This confirms the experience I have in my practice where most of my

clients have more than one disorder , many also have a history of trauma, and other complicating socio-economic or life factors.

Given the complexity and severity of clients presenting under the Better Access program (and they will continue to present under Better Access as there is nowhere else for them to go) they are likely to need and benefit from the specialist skills of clinical psychologists.

To use a sporting analogy, comparing somebody who plays football in the local weekend competition and the international player, both play football, both follow the same rules, and both attempt to score goals. However the local player does not have the skill base, or the knowledge of play and the ability to think strategically, found in the international player. The local player is adequate for the local competition but not for the international competition. A clinical psychologist may be likened to the international player in the generalist psychologist to local player. Both practice psychology under the same ethical rules, both have the same aim to provide clients with good treatment but the skill base and knowledge are different, and the outcomes particularly with more demanding cases are likely to be different.

It is also useful to consider psychiatrists who may also provide psychological therapy. If it is deemed that there is not any difference in treatment provided by clinical psychologists and general psychologists, then given that clinical psychologists have at least as much training in psychological therapy as psychiatrists (who also of course are experts in psychotropic medication), the question would then need to be asked, do generalist psychologists provide equivalent therapy to psychiatrists?

It might be helpful the senators to consider the question: if somebody in your family had a mental disorder of moderate severity or complexity, who would you select to provide treatment, a clinical psychologist or generalist psychologist or a psychologist with specialist training in another area?

5.3 Should that be the difference in payment between clinical psychologists and other psychologists assuming that clinical psychology brings additional benefits to clients seen under Better Access?

There are number of reasons clinical psychologists should receive greater remuneration;

- they use a greater skill set particularly with complex ,more severe or more persistent presentations. This is consistent with Medicare providing greater rebates for specialists such as psychiatrists, and those with greater training. GPs who have undertaken basic mental health training obtain a higher rebates for completing a mental health care plan. It is part of the Australian system that we pay for greater relevant expertise.

– there are many examples in Australia where people with more general training are seen as having less expertise and paid less. Somebody with a business degree that include some basic accounting is not considered to be a chartered accountant, a general nurse with the University degree in nursing is not considered to be a midwife even though they have some knowledge of midwifery.

– The final question as to whether the rebate in fact should be higher for clinical psychologist than it currently is? That GPs who have done 20 hours of focussed psychological therapy training which is far less mental health training than a clinical psychologist, or psychiatrist who does therapy as distinct from providing the medication consultations, are both paid more when there is no obvious reason why this should be the case.

5.4 Implications of abandoning the two tier payment scheme

The Federal government is now a significant employer of clinical psychologists and if the government decided to abandon the two tier scheme this is likely to have a flow on effects to the payment of clinical psychologists under state mental health programs.

Removal of the financial benefit from undertaking the demanding clinical psychology postgraduate training together with a strong message "it's not really worth it, doesn't add anything" is likely to see psychologists choosing not to spend the time and money doing postgraduate study. This will reduce the standards of therapy in Australia.

If the government were to decide that people with training in other postgraduate psychology specialist areas were able to deliver clinical psychology as well as those with specialist training in clinical psychology and pay them the same, it would then encourage people to choose another specialty so that they became for example a forensic psychologist knowing that they would also be a clinical psychologist. In other words why study clinical psychology, when by studying another specialty you are recognised as that specialist as well as recognised by the Federal government as a clinical psychologist.

Since the introduction of Better Access, there was an opportunity (2006-2010) for non clinical psychologists to obtain accreditation as a clinical psychologist through the non-standard route. Psychologists were assessed individually, so that people whose courses have some overlap or increasing overlap with clinical psychology were in fact able to do less additional study than others. In my view it is not appropriate to continue this transition as it did not provide for the breadth of experience at a clinical psychologist has. Psychologists who are now not eligible for the transition program either started the supervised registration or other specialist training, knowing about the Medicare two tier payment arrangements or chose not to take up the transitional program.

6. The adequacy of mental health funding and services for disadvantaged groups, including:

Difficulty in accessing specialist expertise

I provide treatment to people from indigenous and linguistically diverse communities who see me because I also specialise in treating GLBT clients and those with HIV.

Although I received excellent training in working with CALD groups as part of my clinical masters with specialist supervision in this area and I have a good general understanding of a number of different communities I would find it helpful to have access to be able to consult with a psychologist with its clinical psychologist who has particular expertise in working with a particular community when I encounter difficulties.

Recommendation

Fund the provision of specialist consultations with psychologists with community expertise.

ATAPS inhibits members of particular communities seeing a psychologist who is familiar with their community

As discussed above ATAPS is based on local areas (soon to be Medicare Local areas) which do not necessarily reflect the distribution of particular community groups, and more importantly make it extremely difficult for people who belong to a particular community but do not live close to others in that community to access treatment from a provider who has experience in treating members of their community. For example as discussed above I treat a number of gay, lesbian and transgendered clients who choose to travel quite long distances to see me, because of my knowledge of their community and particular issues. However under ATAPS programs I would not be able to see them and it is unlikely that they would find the same level of expertise in their Medicare local area.

If ATAPS services are delivered by psychologists in salaried positions rather than being contracted out to a range of psychologists it may be even more difficult to access community knowledge / experience under ATAPS

Recommendation

Allow psychologists to register with Medicare Locals where they are not physically located and allow the GP and client to select the most appropriate psychologist.

- **GP's are sensible if they see that ATAPS provides better outcomes for their patients they will refer them to ATAPS – it doesn't need changes to Better Access.** GP's are on the ground they understand their patients what is available and best for them

Insufficient coordination with different health professionals

- **Clients may have complex and or severe mental health disorders but this does not mean that they have complex needs** requiring coordination of complex care arrangements- what many need is just sufficient good therapy.

7. The delivery of a national mental health commission

It will be important that the National mental health commission has direct access to the views of individual practicing Allied health professionals as does this enquiry. There is a danger that when individual views are aggregated through professional organisations, that individual data and perspectives are lost.

It is also important that the National mental health commission has the in-house analytical skills and knowledge to be able to undertake its own independent in depth expert evaluations of various proposals and that staff are independent.

8. 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;

We need to look at a combination of the ways we deliver therapy ,particularly for those in the more remote areas. I would like to have the option of using online services as part of the package that I provide clients so that I can provide them with the best service.

Psychologists need to have the ability to deliver therapy over sky or some other secure conferencing medium. In the same way that psychiatrists are now able to do telepsychiatry. I would also be interested in working in some model where whereby maybe monthly, I travelled to the more remote area to meet clients and do face-to-face therapy and then for the remaining three weeks saw them using the Internet.

I also see a number of clients with quite debilitating physical health problems and to be able to have the Medicare item number allowed me to use Skype or some other method when they are unable to attend due to health reasons would be really helpful. It is not practical to trip travel to travel to their homes and may not be appropriate.

9. Other related matters

9.1 The Better Access referral system

The Better Access referral system is difficult to navigate for people with mental disorders as they may have impaired organisational skills and motivation. It is difficult for them to organise a new appointment with their doctor for a new referral and remember to go, before they see me next. It is also difficult when clients return to work or start part-time work as they can find that their working hours do not fit with their doctor's hours and it can be challenging to see a new doctor .Even for the most organised client some doctors are so popular that it may take for five weeks to get a non-urgent appointment, seeing a new doctor just to get a referral seems a bit pointless.

Recommendation: – that is the requirement for subsequent referrals be discontinued which is in line with other specialists.

9.2 Further investigations

The evaluation of psychological services provided under the better access scheme has been limited to allied health workers. It would seem appropriate to also look at the provision of focused psychological strategies by GPs and the provision psychological therapy by psychiatrists.

9.3 Group therapy

Although it is possible for a client to attend 10 (previously 12) group therapy sessions a year under Better Access, the requirement to have six clients in the group before a psychologist can use the group therapy item number , makes it a difficult to establish group therapy sessions, particularly with those in who find it difficult to attend regularly. My understanding is that psychiatrists can do group therapy with fewer clients.

Recommendation:- allow the group therapy item number to be claimed for 2 or more clients

9.4 Session length

Better Access currently provides clinical psychologists with item numbers for session lengths of 30 and 50 minutes. If a 30 minutes session item number is used it is counted as one of the 18 sessions available in the same way as a 50 minutes session would count as one of the 18 sessions. By using the 30 minutes session the clients loses 20 minutes of therapy. This is a considerable disincentive to use the shorter sessions even though there may be clinical need, for example with clients who have drug and alcohol problems and do better with frequent sessions, or with clients who have health problems and do not have the concentration for a 50 minutes session.

Recommendation: – allow 30 minute session to be counted as half a session .

The maximum session length available is 50 minutes, but there are some clinical situations such as imaginal exposure therapy for PTSD where evidence-based practice recommends 90 minutes Australian centre for Posttraumatic Mental Health.(2007) Acute stress and Posttraumatic stress disorder- practitioners' guide).

Recommendation: – introduce new item numbers to provide longer sessions where clinically appropriate.

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