

26/7/2011

Committee Secretary  
Senate Standing Committees on Community Affairs  
PO Box 6100  
Parliament House  
CANBERRA ACT 2600

The Community Affairs References Committee,

Re: Senate Community Affairs Reference Committee inquiry into Commonwealth Funding and Administration of Mental Health Services

Dear Committee Members

Please consider the following concerns that I have identified with regard to the following terms of reference:

- (a) the Government's 2011-12 Budget changes relating to mental health;
- (b) changes to the Better Access Initiative, including:
  - (ii) the rationalisation of allied health treatment sessions, (iv) the impact of changes to the number of allied mental health treatment services for patients with mild or moderate mental illness under the Medicare Benefits Schedule;
- (c) the impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program; and
- (d) services available for people with severe mental illness and the coordination of those services.

As an early to mid-career psychologist in private practice I provide psychological services to, on average, 25 patients with moderate to severe mental health disorders per week. Approximately 90% of my patients are referred by General Practitioners (GPs) and qualify for Medicare rebates under the Better Access to Mental Health Initiative. As such my income is, in the main, derived from providing treatment to patients who pay a gap fee and claim a Medicare rebate. My experience also includes working, in the past, for a range of public mental health organisations, and an inner city Division of General Practice (DGP) under ATAPS funding.

In general, I am seriously concerned about the proposed reduction of Medicare rebates to mental health patients in the private sector under the Better Access Initiative, and the likelihood that the proposed revamped ATAPS system will not be adequate to supply the required sessions to accommodate those patients who will have sessions reduced under the proposed changes to the Medicare scheme. The result of these proposed changes is that those patients who require services most will be left waiting for services from a new practitioner in a new system and meanwhile will require maintenance services from their referring GP.

In short, the consequences of the proposed changes are, in my view, very clear - reduced services to those affected by moderate to severe mental illness (currently approximately 5%), who obviously need those services most, will result in the burden of care being carried by GP's. As the ATAPS system is not adequately funded and, in my opinion, not well organised at present, the reduction of session numbers in the Better Access scheme will increase psychological pressure on patients who will turn to GPs to provide treatment, and ultimately this will increase the overall cost of mental health care, whilst simultaneously providing less effective services. As the head of the AMA said last week at the press club, and I agree, if these proposed changes occur, we can expect 'a wave of unhappiness'.

It is my understanding that the recent Federal Budget announced funding cuts to the Better Access to Mental Health scheme initiative involving a cap on the maximum number of allowable sessions of psychological treatment a client can receive per calendar year. From 1 November 2011 this will be capped at 10 (6+4), with no 'exceptional circumstances' that allow additional sessions on top of the 10 allowable sessions. In my experience those patients who present with more severe mental illness consistently attend 18 sessions annually and many more (up to 45) if they are able to afford the full fee. Therefore it appears inevitable, under the proposed changes that these patients will either have their service terminated prior to the completion of their psychological treatment, or will have to move to services proposed under the revamped ATAPS system, or return to their GP for psychological treatment, or when these services aren't available they will present at hospital emergency wards.

My concern is that under the proposal for the ATAPS system not only will these distressed patients have to change practitioners in the course of their treatment, but that it is highly likely that they will be required to wait for a service due to the reduced numbers of psychologists practicing in the ATAPS system compared to the Medicare scheme. This will result in patients with severe mental health problems returning to GP's for regular maintenance sessions. Having worked in the former ATAPS system I have no doubt that patients with severe mental health illness will be worse off under the proposed changes. Overall, my experience with this system tells me that the ATAPS system is less cost effective, more inefficient, and encumbered with additional paperwork. In my experience it was a frustrating system to work within for both psychologist and patient and the stresses involved result, unfortunately, in a poorer service of care.

My concern about the inadequacy of the ATAPS system to manage new referrals is already being verified by the recent announcement of my local inner city DGP who have informed me (05/07/2011) that increased ATAPS funding will provide just 30 additional clients psychological services annually. This means that unless this funding changes dramatically and immediately, with the reduced number of sessions available to all patients, including those with severe mental health difficulties, and with the current limit to ATAPS funding, less services, but at a greater cost to the consumer will be provided, resulting in an increased burden on GP services and a greater cost to the general community.

According to the data ascertained in the review of the Better Access to Mental Health Initiative the proposed cuts to mental health services are likely to adversely affect the very small percentage (i.e., 5%) of patients who need it most, so it appears to be a cut that will eventually cost rather than save the taxpayer money. A further concern is the cuts to GP rebates for their contribution to patient assessment and referral. Without GPs having a range of incentives to triage patients through to psychologists fewer patients will receive treatment for mental illness. In my experience GP's who care about mental illness work hard to make useful psychological assessments and referrals, which takes time, and I believe they should not be discouraged from these efforts. Therefore, in summary, please carefully reconsider cuts to session numbers. In my experience it is the later sessions in a course of treatment that make so much of a difference to positive outcomes. From what I understand the Better Access Initiative has been working well so far, and common sense dictates that those most in need for treatment for severe mental illness should be entitled to more treatment sessions rather jeopardise outcomes with fewer sessions as is proposed.

Please also consider my additional concerns with regards to the following terms of reference:

- (e) mental health workforce issues, including:
- (i) the two-tiered Medicare rebate system for psychologists,

- (ii) workforce qualifications and training of psychologists, and
- (iii) workforce shortages

My concern about the proposed abolition to the two-tiered Medicare rebate system for clinical psychologists relates to the fact that in order for my patients to qualify for the higher rebate under the Medicare rebate system, at considerable cost, I have been required to undertake higher level training than the training that was provided in the Masters program for psychologist registration. The requirement of additional training was mandatory in order for eligibility to allow patients to qualify for a higher rebate. Having undertaken this additional training, over a period of two years, my skills have improved to provide psychological diagnosis and treatment to patients over the course of the whole lifespan with the most complex mental health presentations, including personality disorders and multiple diagnoses. It is my understanding that the additional training that I have undertaken has increased my knowledge and understanding of clinical psychology to equip me to provide the optimal clinical service. It does follow, in my experience, that the clinical psychologist is the most highly trained psychologist for the treatment of mental health. As a clinical psychologist with the requisite training I have found myself in a position of leadership providing supervision to other psychologists in organisational settings and in private practice.

In my opinion there are two main likely consequences of removing the increased rebate for clinical psychologists. The first is that patients with the most complex and severe mental health conditions are likely to be penalised by being charged greater out-of-pocket expenses to pay fees to clinical psychologists, who have spent considerable amounts on their additional and ongoing training. Therefore, due to higher out-of-pocket costs those most needy patients are unlikely to receive as many treatment sessions, which will result, as indicated above, in these patients returning to GP's for maintenance while waiting to be transferred to the ATAPS system. This will result in a delayed and inferior approach to psychological treatment for those who need it most, increase stresses on GPs who will be required to manage distressed patients, increase patient suffering, and ultimately increase costs to the Medicare system. In addition, reducing the patient rebate is likely to see the end of all bulk billed sessions I was able to provide, which means that the most financially disadvantaged patients will be refused treatment at the outset.

The second consequence that I envisage of reducing higher rebates for clinical services is that it will remove an incentive to those psychologists with an interest in additional training to provide treatment to more complex clients to undertake the necessary training, which may likely result in less well trained psychologists providing treatment to the most needy patients in the future. And, finally, the general incentive to pursue further significant training and to lead teams will be reduced. As I understand it under the current system any psychologist who wishes to undergo the necessary additional training is able to, once acceptably qualified, be endorsed for their patients to receive the higher rebate. In short, removing incentives for psychologists and doctors to train and work with severe mental illness will quickly reduce positive outcomes for the most needy patients.

The most obvious solution to the problems of increased costs to the community and reduced services to those most in need which will inevitably follow the proposed changes is to authorise clinical psychologists, and those psychologists with the equivalent advanced training, to provide as many services as they assess as necessary to treat their patients, in the same manner as psychiatrists, who are able to claim a rebate for each session they assess as necessary, without the restriction of providing a restricted number of sessions. It is obvious to practitioners of psychology and psychiatry that more severely affected patients almost invariably require upwards of 30 sessions and generally make little progress in 10 sessions. Obviously by restricting session numbers the nature of the treatment is restricted and the outcome is jeopardised. By authorising clinical psychologists to provide treatment according

to patient need the treatment is probably more likely to be effective and ultimately more cost efficient.

In summary, it is my view that the proposed changes to the Better Access Scheme, ATAPS and reduced Medicare rebates for clinical services will increase the burden on GP's, increase the cost to Australian taxpayer, and reduce the effectiveness of the treatment of mental health, especially to those patients who need it most, that is those suffering the greatest mental health distress and those most financially disadvantaged. In my view the better alternative to reduce the burden on GP's, the taxpayer, and to increase the quality and effectiveness of mental health treatment, is to retain the Medicare rebate system with up to 18 sessions, to remunerate clinical psychologists and their equivalents commensurate with their higher level training and skill, and to authorise clinical psychologists to provide rebate funded psychological treatment to patients, not as proposed with a greater restriction on the number of sessions, but according to need, as is currently and sensibly the case for psychiatrists. This final point may be the best way to provide those patients most in need with an effective treatment service they require while minimising overall costs to the mental health system.

Finally I have opted to provide this submission anonymously due to threats made by a group of psychologists claiming to represent all psychologists who are agitating to boycott psychologists who advocate for the retention of the current system.

Thank you for considering my viewpoint on these important matters.