Submission Against Federal Budget Cuts to the Better Access Initiative

In view of the Medicare session data not distinguishing patterns according to severity of disorder, the APS 2010 audit survey of 9,900 clients who required more than 10 sessions of treatment under Better Access. It shows that the vast majority had moderate to severe or severe mental health disorders involving depression and anxiety disorders and that they received effective psychological treatment.

Of the clients who required more than 10 sessions of treatment:

- **80.8%** had an ICD-10 mental disorder involving depression or anxiety disorders, also known as „high prevalence disorders".
- Only a very small number had a „low prevalence disorder" – **3.0%** had a psychotic disorder and **4.5%** had a diagnosis of bipolar disorder.
- On referral, **83.6%** were rated by the treating psychologist as having a moderate to severe (40.5%) or severe presentation (43.1%) and only **0.2%** were rated as having a mild presentation.

These people would be denied access to effective psychological treatment under the Better Access initiative under the proposed funding cuts.

The recommendation that these people should be referred to a consultant psychiatrist is not realistic as there is a significant shortage of psychiatrists and anecdotally most charge a prohibitive gap fee in the range of $200 per session.

The ATAPS program run through the Divisions of General Practice (DGPs) is not a viable referral option under current arrangements. There is not enough funding and a significant proportion of the funding for mental health services is spent on administration rather than providing psychologists to deliver the services.

The Government's own evaluation of Better Access demonstrated that it is a cost-effective way of delivering mental health care. The typical cost of a package of care delivered by a psychologist under the initiative is $753, significantly less than ATAPS which costs from two to 10 times that of Better Access per session. Successful treatment also reduces costs of hospital admissions and allows many consumers to return to work, with the associated productivity benefits.

The data confirm that the Better Access initiative is providing effective treatment for the people it was designed to treat – those with high prevalence disorders.

My Own Experience

In my practice, I see mainly women over 40 years old with depression and anxiety. Very few of my clients come less than 10 times a year. I have a fee scale for financially disadvantaged which many clients access from $5 to $30. These clients include pensioners, single mothers, low income earners and their children. This allows clients dignity and the chance to continue therapy until their issues are resolved or under control. I have a lot of long term clients who could not otherwise afford psychological services.

My clients who see psychiatrists have short appointments from 5 to 30 minutes usually about 15 minutes. The purpose is usually to manage the client's medication. Very few psycho-education, positive thinking strategies or relaxation skills are used by their psychiatrists. In fact one psychiatrist when asked about these interventions told the client to ask her psychologist to work with her on them.

I also do volunteer work weekly at an inner city neighbourhood centre. There I see clients who are homeless, alcoholic, drug addicts, abused and unemployable who live on or below the

poverty line. The centre provides showers, laundry facilities, free community programs, referrals to other agencies, free computer access, free tea and coffee and a pleasant garden to sit and chat in which was constructed by the clients.

These clients have accompanying mental health issues and fly below the radar of private and government programs. Once a relationship is established with me outside the counselling room, these clients start to trust and ask to come inside the counselling room to talk with me. As I provide a free service the clients appreciate it more, particularly the confidentiality. Most clients especially with long term co-morbid conditions do not trust government or organisations and would experience great difficulty and trauma if they were to try to navigate the GP referral or public hospital system.

I am concerned that crucial funds are being redirected from the Better Access initiative, the most successful mental health program in the last 30 years. The evaluation of the Better Access initiative showed that increasing access to evidence-based psychological interventions reduced the impact of mental illness in a highly cost-effective way. This program is widely used by Australians with moderate to severe mental disorders, and reducing the number of sessions available for treatment will decrease the quality of overall service provision.

The reduction of the number of sessions of psychological treatment available will impact upon its effectiveness for the people who most need it. This will do nothing to improve mental health service delivery overall.

I am advocating strongly for the maintenance of existing Better Access funding arrangements in light of the Federal Budget cuts to the number of sessions of psychological treatment available to Better Access consumers. In fact I propose an extension of services to people who live on or below the poverty line by funding psychologists in the community where they live and making these much needed services more accessible.

PSYCHOLOGIST