The current submission pertains to:

1. The changes to the Better Access **Initiative including:**
* rationalization of allied health treatment sessions.
*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;

1. Changes to the Better Access **Initiative**

The Government's latest Federal Budget aims to further restrict people's access to Psychologists, reducing the number of allowable sessions for people with a diagnosed mental illness from 18 (not from 12 which has been widely reported in the media) to 10 per calendar year. Reducing the number of allowable sessions will severely restrict access to effective mental health treatment.

The Government's own evaluation of the *'Better Access Initiative'* has shown it to be a cost-effective way of delivering mental health care and the initiative was successful in increasing treatment uptake, which was one of the Government's initial goals. Given the success of the Better Access Initiative, and the evidence which supports its popularity with the community, it seems counter-intuitive that the Government would now try to reduce private Psychology treatment for people with mental illness.

Cost-Effectiveness of Better Access
The Federal Government's own evaluation of the *'Better Access Initiative'* has shown it to be a cost-effective way of delivering mental health care. The typical cost of a package of care delivered by a Psychologist under the initiative was $753.00 - significantly less than AT APS which costs 2-10 times more than the *'Better Access Initiative'* per session. More so, successful treatment has the potential to reduce costs of hospital admissions, and social security payments, and allows many consumers to return to work, with the associated productivity benefits.

The ATAPS program run through the Divisions of General Practice (DGPs) is not a viable referral option under current arrangements. Even with the Federal Government doubling the AT APS funding, there is simply not enough to provide services for the estimated 260,000 consumers (or 86,000 per annum). Furthermore, a major issue is that a significant proportion of the funding for mental health services received by DGPs is spent on administration rather than providing funding to the Psychologists who are engaged to deliver the services.

Anecdotally, clients have reported being unable to access Psychological treatment under AT APS towards the end of the funding year, because the funding had run out.

This resulted in a vulnerable population not being able to access Psychological services under this program.

The Federal Government has also proposed that if individuals require more than 10 sessions of Psychological treatment, they can be referred to a Consultant Psychiatrist. However, the majority of Psychiatrists have lengthy waiting lists and may not offer or specialise in the application of psychological based treatments.

With the funding cuts to Psychologists under Better Access, it is likely that there will be an increase in consumer presentations to GP's and hospitals.

In 2006, the Council of Australian Governments (COAG) released a National Action Plan on Mental Health (2006-2011) (14 July, 2006, p.3), which stated that *"people with mental illness often require access to a range of human services provided by Commonwealth, State and Territory governments and the private and non-government sector. Better coordination of all these services can help to prevent people who are experiencing acute mental illness from slipping through the care 'net' and reduce their chances of readmission to hospital, homelessness, incarceration or suicide. Better coordinated services will also mean that people can better manage their own recovery"*.

As highlighted by COAG *"an effective care system will provide timely and high-quality health and community services to people with a mental illness that assists them to live, work, and participate in the community. An effective, integrated care system has several parts working well together, which can include psychiatrists in the community and a primary health care sector of GPs, psychologists, mental health nurses, and other allied health workers that provide clinical services to people with mild, moderate and severe mental illness, including early identification, assessment, continuous care and case management"*.

COAG identified in the National Action Plan that the *'Better Access to Mental Health Care Initiative'* would serve to enhance the provision of care to individuals with recognized mental health illness of mild, moderate, and severe natures. The Government's own evaluation of the *'Better Access Initiative'* has shown it to be a cost-effective way of delivering mental health care.

In addition, an Equitable Life Assurance study in America found a $5.52 increase in productivity for every $1 spent on Cognitive Behaviour Therapy for stress-related disorders (WA Work Value submission, 2001).

Burden of Disease

Recognition of the extent to which mental illness contributes to overall ill health and its economic implications has increased substantially in recent years. Although mental disorders account for only 1% of deaths, they are responsible for an estimated 11% of disease burden worldwide.

The World Health Organization (WHO) projected that this will rise to 15% by the year 2020. Within Australia, the Australian Institute of Health and Welfare reported

that mental illnesses are the largest single cause of disability in Australia, accounting for 24% of the burden of non-fatal disease (measured by total years of life lived with disability).

Given the high and increasing economic burden of disease associated with mental illness in Australia, the cutting of any mental health initiatives or programs that have demonstrated cost-effectiveness in the treatment of recognised disorders, is not recommended, and will undoubtedly result in more money being spent in the future to try and reduce Australia's burden of disease from mental illness.

Evidenced-Based Treatment

Reducing the number of Psychological treatment sessions from 18 to 10 will reduce the effectiveness of Psychological interventions, will result in fewer remissions from mental disorders, and increase the chances of relapse for consumers. This is based on scientifically researched, empirical evidence, recommending 15-20 sessions of therapy for common mental health disorders. For example:

1). The National Clinical Practice Guidelines as established by NICE (National Institute Clinical Excellence, UK; 2005) recommended the following amount of treatment sessions specific to each recognized and diagnosable mental health disorder:
- Posttraumatic Stress Disorder = 8-12 sessions
- Generalized Anxiety Disorder (Source 3, p.17) = 12-15 sessions
- Panic Disorder (Source 4, p.17) = 7-14 sessions
- Major Depressive Disorder (Source 5, p.28-29) = 16-20 sessions

2). In 2009, the Australian Centre for Posttraumatic Mental Health and Rural Health released Guidelines for the treatment of a Simple PTSD, which recommended 8-12 sessions. A more complex PTSD presentation (i.e., several problems arising from multiple traumatic events, traumatic bereavement, or where PTSD is chronic and associated with significant disability and co-morbidity) recommended further sessions using specific treatments to address the problems.

3). The Australian Psychological Society (APS) conducted a literature review, which recommended the following amount of treatment sessions specific to each recognised and diagnosable mental health disorder:
- Adjustment Disorder = 14 sessions
- Eating Disorders = 15-20 sessions
- Phobic Disorders = 12 sessions
- Genera1ised Anxiety Disorder = 14 sessions
- Panic Disorder = 7-14 sessions
- Obsessive-Compulsive Disorder = 12 sessions
- Major Depressive Disorder = 16 sessions
- Drug and/or Alcohol Disorders = 52 sessions

It is important to note that co-morbidity of mental disorders has a high prevalence, and the majority of consumers present with more than one diagnosable mental disorder, hence requiring additional treatment sessions than noted above.

The proposed Federal Budget changes to the *'Better Access Initiative'* does not seem to take this evidence into account, disregarding clinical recommendations, and seemingly disregarding the diverse needs of Australians with mental health disorders. The number of Psychology sessions should be empirically determined and aligned with clinical recommendations of demonstrated treatment outcomes, rather than simply qualifying mental illnesses as 'severe' or 'less severe'.

In summary, given that treatment by Psychologists has been found to be effective, cost-effective, and has met the Government's initial goals of the Better Access Initiative, it does not seem logical that these sessions would now be cut. Especially in light of the WHO predicting that the burden of disease accounted for by mental illness will rise to 24% in 2020 if the correct action is not taken now. And the evidence supports that treatment by Psychologists is the correct action.

It is recommended that the Senate Enquiry re-instate the 18 session allowance per year to consumers. Continuing with the Budget recommendations will ultimately introduce inequality to the provision of standard evidence-based therapy wherein only the most disadvantaged and vulnerable (those with the "more severe" mental illnesses) are unable to afford to complete their course of treatment.

Thank you for investigating this issue