

The Government's funding and administration of mental health services in Australia, with particular reference to:

(a) the Government's 2011-12 Budget changes relating to mental health;

Budget changes are based on evaluation data regarding consumer use of Mental Health Services under both the Better Access to Mental Health and Better Outcomes in Mental Health Initiatives (In particular ATAPS).

I question the integrity of evaluation data in terms of how many sessions are utilized for the treatment of a mental health disorder.

Currently there is no system that ensures individuals do not utilize both Better Access and Better Outcomes systems. I work in a Division of General Practice and too often we are informing GPs that patients cannot use both systems. It is currently easy for patients to be referred under ATAPS and following 12 sessions per calendar year, attend a different GP (or at times the same GP) for a Mental Health Treatment Plan review and then receive a referral for further sessions under the Better Access initiative. Although GPs and AHPs should be regulating the use of both systems, GPs are restricted in time and do not have adequate resources to follow up with patient's previous referring GP to determine how many sessions they may have had under one initiative. Additionally (realistically) GPs do not always keep track of the number of sessions a patient has had. AHP may also continue to see patients for more than 12 sessions per calendar year rationalizing that it is in the patient's best interest and knowing that there is currently no system in place where the total number of sessions a patient received (under Better Access and Better Outcomes) can be immediately identified.

Overall this may lead to inaccurate (underestimation) data regarding how many sessions patients are actually receiving for treatment of their mental health issues.

An cross reference audit of Division of General Practice ATAPS records (those that record patient details for the purpose of managing the program) and Medicare item claims would likely highlight any concurrent use of both systems and thus validate or invalidate evaluation data pertaining to the number of sessions used/required for the treatment of a mental health disorder.

(b) changes to the Better Access Initiative, including:

(i) the rationalisation of general practitioner (GP) mental health services,

I question any rationalizations that would suggest that a GP who undertakes a brief training in the delivery of focused psychological strategies would be able to adequately deliver such strategies while an AHP needs to train for at least 6 years in order to be able to deliver such strategies.

(iii) the impact of changes to the Medicare rebates and the two-tiered rebate structure for clinical assessment and preparation of a care plan by GPs, and

(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

Cognitive Behavioural Therapy is a structured therapy that often draws upon the medical model of Diagnosis + Standardized Treatment = cure. The standardized (manualised) treatment for clinical disorders (in particular depression and anxiety) is generally 12-20 session. Reducing the number of sessions is inconsistent with a wealth of research

I feel that 10 sessions would discriminate against those individuals who have more moderate to severe mental illness. Realistically the severity of a mental illness cannot be determined by a 15 minute GP assessment or a K10 or DASS psychometric which only looks at current symptoms in the past month or week. Severity thus would be quite variable and individuals who may present with mild or moderate symptoms one week may present with severe or extremely severe symptoms the next week. These individual would be disadvantaged by only being able to have 10 sessions with no exceptional circumstances.

Ultimately the changes discriminate against those individuals who have more severe mental illness by not allowing them adequate treatment or by making it harder for them to access adequate treatment.

(e) mental health workforce issues, including:

- (i) the two-tiered Medicare rebate system for psychologists,**
- (ii) workforce qualifications and training of psychologists, and**

There is no empirical evidence to suggest that a Clinical psychologist are in any way better at treating patients with mental illness than other generalist psychologists.

The two tier rebate system suggests that clinical experience does impact on ones ability to treat mental illness effectively. Rather the system suggests that an individual who has just completed a Masters in clinical psychology would be more effective than a generalist psychologist who has 30 years of experience working with individuals with mental health disorders.

Furthermore, the difference between University programs for counseling and clinical streams is minimal with some institutions only varying the programs by one subject. Although training placements do account for some experience under different specialties (e.g counseling and clinical), it is quite plausible the a counseling psychologist may gain more clinical experience than a clinical psychologist during a masters program depending on their supervised placements. Thus the two tier rebate system is not reflective of any 'real' differences between clinical psychologists and counseling psychologists and ultimately misleads the public regarding a psychologists expertise.

