

I am a Clinical Psychologist working primarily in the public mental health system who is also part-time in private practice in a relatively disadvantaged part of Melbourne, seeing individuals referred through the local 'Access to Psychological Treatment' Program (Federally-funded program through the Division of General Practice) and the 'Better Access to Mental Health' program (Federally-funded via Medicare). I am writing regarding proposed cuts and changes to the latter, announced in the Federal Budget.

Firstly, I want to thank and congratulate all those who supported the direction of increased overall funding to mental health services in the budget. This is a progressive step which will yield benefits in the health of individuals afflicted with mental health problems, but is also a sound economic investment likely to improve work participation and productivity rates, and social inclusion, along with reducing the burden of disease associated with untreated conditions over time.

However, I am concerned about some unintended impacts of the changes proposed upon access to service, service provision and ultimately treatment outcomes for mentally ill people. I want to address particular points in the Terms of Reference of this Senate Inquiry as follows:

b) Changes to Better Access Initiative

i Rationalisation of Allied Health Services

Preliminary research commissioned by the Federal Government on the Better Access program suggests about 80% of individuals accessing the program use under 12 sessions per calendar year. These people have been deemed to be experiencing mild to moderate mental health problems, for example generalised anxiety disorder or mixed depressive/anxiety disorder, though there are recognised deficiencies in the methodology of the study upon which this estimate is based.

Complimentary research recently undertaken by the Australian Psychological Society (APS), the details of which will be included in the APS submission to the Inquiry, suggests that the around 20% of individuals in the 'Better Access' program who use between 11-18 sessions per calendar year, have moderate to severe mental health problems and co-morbid conditions/dual diagnoses. For example, an individual may have major depression and a personality disorder, or a psychotic disorder and a substance-use disorder. Moderate to severe and/or co-morbid mental health conditions are more likely to become chronic and relapsing, and to require longer and more specialised treatment.

Individuals with moderate to severe and/or comorbid mental health conditions commonly also have trouble accessing the treatment they need within other, existing services. Many of these people are not eligible for treatment in the local public mental health service because only the smallest minority meet the criteria for inclusion (eg being at imminent risk of self-harm or serious deterioration in their mental health). Further, those who do obtain some treatment via the local public mental health service generally access medical management and/or case-management, but only limited psychological treatment because such treatment is not resourced and thus provided by those services.

These people may also not be able to access the mental health treatment they need through Access to Psychological Treatment Programs (ATAPs) run by local Divisions of General Practice (DGP) for a number of reasons. Firstly, not all GPs are engaged with their local Division and thus using its ATAPs program. Secondly, I have found that Divisions run uniquely according to their own policy priorities and management approaches (eg targeting people with mental illness at risk of homelessness), which means that some individuals with mental health problems will always fall outside the particular priority areas of the local Division, making them ineligible for the service. Thirdly, I have found that the number of psychological treatment sessions provided under an ATAPs Program is sometimes less than available under 'Better Access' because Divisions are implementing demand-management strategies. This can lead individuals who access treatment via ATAPs programs to be unintentionally disadvantaged in the duration of treatment they receive, in comparison to those accessing treatment via 'Better Access', though this may not have been an informed

choice. Finally, many ATAPs Programs pay Psychologists less than the scheduled Medicare fee for the same service, which is a disincentive for Psychologists in general to participate in the programs but also likely leads those who do to be less experienced and less well-trained. Thus, reducing the number of treatment sessions available from up to 18 to 10 per calendar year is likely to reduce access to and effectiveness of psychological treatment for individuals with mental health conditions, especially those with moderate to severe and/or comorbid conditions, who are the most vulnerable, least well-served currently, and impose the most social, economic and other health costs within society. I believe that the current system should be maintained, with individuals deemed by the referring G.P to meet 'Exceptional Circumstances' (to have a deterioration in their mental state or new mental health needs have emerged), be able to access up to 18 treatment sessions per calendar year.

iii Impact of changes to the 2 tier rebate structure for clinical assessment & preparation of care plans by G.P.s

Mental health assessment and care-planning are tasks requiring genuine interest and commitment to the field of practice, and some specialist skills. This was recognised when the ATAPs programs initially began in the early 2000s, because only G.P.s who had completed mental health assessment training modules were eligible to use the program. It was also subsequently acknowledged when the 'Better Access' program began within Medicare, through a 2 tier rebate system for G.P.s doing mental health plans ie those with mental health training attract a higher rebate than those without. Removing the 2 tier rebate system for G.P. mental health plans is a disincentive to all G.P.s to undertake this vital work, and especially to those who have demonstrated special interest and skill because this will not be renumerated as such. This is likely to lead more G.P.s with mental health assessment training to cease this part of their practice, or to continue but to reduce the amount of time/effort they place into the process. This will further threaten access to psychological treatment for individuals with mentally health problems, and/or the effectiveness of the mental health care provided.

iv Impact of changes to number of Allied Health Treatment sessions for people with mild to moderate conditions

Please see b & e

e) Workforce Issues

i The 2 tier rebate for Psychologists

As described above, the provision of mental health care is specialised, with the two disciplines which are central providers of same, Medicine and Psychology, each regarding this as an area of specialised practice. Hence, Psychiatry is a specialisation within Medicine, and Clinical Psychology is a specialisation within Psychology. Qualifying as a Clinical Psychologist requires a minimum of 8 years training and this is the only profession, apart from Psychiatry, whose entire accredited and integrated postgraduate training is exclusively in the field of lifespan, evidence-based psychopathology, assessment, diagnosis, case-formulation, psychopharmacology, clinical evaluation and research, across the full range of severity and complexity of presentations. Clinical Psychology is an area of specialist endorsement for Registered Psychologists, enshrined in national legislation overseen by AHPRA.

Further, Clinical Psychology qualifications have been recognised as the standard of practice in the field of public mental health, where more severe and complex mental health problems are treated. The Industrial Relations Commission has endorsed the calling of Clinical Psychology as being of higher work value than the calling of Psychology, embedded this in relevant Industrial Awards such as the Medical Scientists and Psychologists Award, which is the award under which Psychologists are employed in health services. This award requires that Psychologists employed in mental health services, have Clinical Psychology qualifications.

This specialisation in the provision of mental health care was recognised when the 'Better Access' program was established, with Clinical Psychologists attracting higher rebates than (generalist) Psychologists. Dismantling the 2 tier rebate for Psychologists will be a

disincentive for the most qualified and experienced professionals to continue providing psychological treatment services, reducing access to effective treatment for individuals with mental health problems across the board, but especially for those with moderate to severe and/or comorbid/dual-diagnoses, who require the most expert care. It will also set-up an inconsistency between the standards of care in different types of government-funded mental health services, with patients of public mental health services being treated by Clinical Psychologists and those obtaining treatment via 'Better Access' (Medicare) receiving treatment by Psychologists who have no specialist mental health qualifications.

ii Qualifications & training for Psychologists

Please see e.

As a Clinical Psychologist in private practice working under the 'Better Outcomes' program, I work closely with local G.P.s and public mental health services to provide complimentary psychological therapy which their patients need and which cannot be provided in any other way. I also always have a proportion of patients whom I bulk-bill, in order to ensure that highly vulnerable people with mental ill health can obtain the treatment they need. For all these reasons I urge you not to implement the proposed cuts in number of psychological treatment sessions under the program, not to dismantle the 2 tier rebate system for G.P. mental health plans, or to consider dismantling the 2 tier rebate system for Psychologists. All of these things would greatly reduce access and effectiveness of treatment for those in most need, and will be accompanied by accumulating social, productivity and economic problems over time.

Yours faithfully,

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