4/8/11
Committee Secretary
Senate Standing Committees on Community Affairs
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Parliament House
Canberra ACT 2600

I wish to submit the following document addressing the terms of reference of the inquiry into mental health service funding and delivery.

(b) changes to the Better Access Initiative, including

(ii) the rationalisation of allied health treatment sessions,

The justification for the proposed reduction in the number of allied health services under Better Access is, in my opinion, based on conclusions drawn from a biased and possibly misleading review.

Here are the instructions that psychologists were given in the review: http://better-access.org/pub/Main/WebHome/General_Psychologist_Detailed_Instructions.pdf

Step 6 on these instructions (top of page 5) show where some of the confusion was for practitioners in the study. Here the researchers state that "the evaluation is only looking at a single episode of care" and that even though the consumer may return for further treatment, "this is not considered within the bounds of the episode of care and we will not be collecting data".

Evidence has now emerged that some practitioners have taken an 'episode of care' to mean a 6 session block of treatment.

Given that the instructions clearly state that there is no room for further treatment in that year to be counted (even if further treatment did in fact occur), it appears straightforward that these statistics cannot fairly be used to justify cuts in the maximum allowable number of sessions.

That is, the claim that we are hearing that most clients did not use more than 6-10 sessions is baseless, because the researchers have plainly stated here in the instructions that they did not collect data about further treatment. If they didn't collect the data, then there is no valid basis for making these claims.

Better Access is criticised for not reaching all areas of the population effectively. The same criticism is made of ATAPS as well. Perhaps, instead of pulling money out of a program described as 'the most successful mental health program in the last 30 years.

(APS media release 11/5/11), more funds should be invested in order for Better Access to reach its full potential. For instance, increasing the rebate for service providers in rural and remote Australia would make practicing in these areas more attractive. The government should look to provide more carrots, and less sticks, if they want services in rural and remote Australia increased.

(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

If rebates for GP's are reduced then what incentive to they have to complete the Mental Health Care Plan referral to a mental health clinician when rebates for other care plans (chronic disease) remain unchanged? Why is physical health valued more than mental health?

(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;

What we are looking at, in my opinion is the reduction in opportunity to prevent people with mental health problems deteriorating to a state where they need hospital admission. I speak from personal experience working with the consumers I do, that sessions through Better Access, 12 and beyond, have kept people from needing hospitalisation. Just think about the money saved, and quality of life maintained.

Mental health inpatient care is expensive, around $1000 per day. A course of 18 sessions through Better Access costs between around $1400 to $2200. So imagine, the amount of inpatient bed/days saved by consumers being able to access timely, affordable and individually tailored treatment. My hypothesis is that it is those consumers who have utilised all 18 sessions who are most likely to have needed hospitalisation without access to the exceptional circumstances extra six.

Also, Better Access is just that, more access for ALL Australians. The money going to headspace and EPPIC, while important, target a relatively small segment of the community and low prevalence disorders. Better Access lets those who don't fit into other categories get mental health treatment, in the least stigmatising fashion ie, they don't need to go to a 'centre'; private practitioners operate in community locations. Further to this, stigma may prevent some consumers from accessing centre based care, especially in rural and regional areas. In a town where most people know you or your family, would you want to be seen going into a mental health service if you knew it would reflect badly on you or your family?

Places like headspace and EPPIC will only be established in population dense areas.

Better Access allows clinicians to practise anywhere in Australia, and is especially good for those in rural and regional areas. So, services are available in their local area. If you don't have a car, have money or mobility problems, accessing treatment in your local community is essential.

The proposed changes also affect clinicians and their ethical responsibilities to consumers, that is, being able to provide suitable treatment for their condition. Evidence based literature shows that more than 10 sessions are needed to treat most conditions. By reducing the number of sessions, clinicians are at risk of not being able to provide effective, individualised, evidence based, suitable treatment.

I am distressed to see the number of people (who in my opinion should know better) spouting forth the line that Better Access is just for the 'worried well'. Even a cursory reading of the Better Access reviews shows that a significant number of people accessing this service are experiencing severe levels of distress. Treatment through Better Access was also effective at reducing that distress.

(c) the impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program;

ATAPS is run according to how each division of general practice sees fit. This leads to an inconsistent service with major pitfalls. A large proportion of the funding is spent on administrative costs, taking away from direct clinical services. Better Access, the direct fee for service does not have these overheads, as they are funded by the practitioner themselves.

The reimbursement of clinicians varies from division to division, with little or no scope to charge a gap fee. This means that for some clinicians, providing contracted services to ATAPS means a pay cut. The outcome of this is that clinicians have to see more consumers per day to make a fair wage and cover their costs, and also that it may be the more inexperienced clinicians who will take this work up. This then, leaves a gap as more experienced clinicians will work elsewhere.

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

The two tiered rebate in its current form is discriminatory against those psychologists who have undertaken advanced training in there are of expertise. Clinical psychologists do not have a claim to being the only specialty which deals with mental illness. Counselling psychologists (as recognised by AHPRA) and also those psychologists who complete their two year internship in mental health services also have specialist skills in the delivery of mental health services.

Perhaps, this rebate should be extended to those other specialties recognised by AHPRA as well as those psychologists who undertake their internships in specific mental health placements?

I am saddened that some clinical psychologists want to throw the rest of their mental health service providing brethren under the proverbial bus to save themselves from a review of their rebates. This is a time where we should be united in our commitment to providing the best services possible to our clients, not bickering amongst ourselves.

Also, I note that some example cases have been used to justify how superior clinical psychologists are compared with other clinicians. This anecdotal evidence can easily be countered by anecdotal evidence to the contrary. I have seen a number of clients who have seen clinical psychologists before me, and found them wholly unsatisfactory and too ridged in their approach. It cuts both ways. The actual scientific evidence does not support the superiority of any one allied health profession. In fact, and other submissions have made this claim, up to 40% of the outcome of therapy is related to the relationship between the therapist and the client.

(ii) workforce qualifications and training of psychologists,

Firstly, psychologists only practice in areas in which they are competent. There are a wide range of areas that can be specialised in within the psychology profession. I would hope that psychologists operating through Better Access are doing so because they have experience in mental health.

Secondly, the training of psychologists has become increasingly onerous for those who go the 4+2 route (4 year degree, 2 years supervised training). One could argue that it is as equally demanding as a masters degree, given the amount of documentation, tasks and time required. While the safety of the public is paramount, the quality of, and the amount of time and energy put into completing the +2 must not be overlooked.

Many of the psychologists I am aware of who are in private practice all undertook their +2 at community mental health services, and have many more years of service in mental health. These are the services that see consumers who are the most unwell, most severe and have the most chronic illnesses. Psychologists in these situations are supervised by other psychologists or clinical psychologists with extensive experience in mental health diagnosis and treatment. They also often have access to psychiatrists for further input (although it must be remembered that psychiatrists are an endangered species once one crosses that great dividing range).

(iii) workforce shortages;

Any tightening of restrictions on psychologists, mental health social workers or occupational therapists will only increase workforce shortages, especially in rural areas.

The government has argued that a reduction to 10 sessions is ok, partly because people can access up to 50 sessions with a psychiatrist per year. As already mentioned, access to psychiatrists in rural and remote Australia is difficult if not impossible for a number of reasons including cost and travelling to major towns for appointments. Also, psychiatry does not equal psychology (or social work or mental health occupational therapy). It is not appropriate to say to someone they have to see a psychiatrist because they have used their 10 sessions. Building trust with a therapist takes time. Having to start at the beginning, building a new relationship with a new person (who's therapeutic orientation might be diametrically opposed to your previous therapist's) is not a good way to deliver treatment. Most psychiatrists specialise in the prescription of medication, few do talk therapy, especially in rural areas. So, the two services are complementary, but not substitutable.

Increasing access in rural and remote Australia can be done with Better Access, if there are incentives to provide services in these areas. The government should consider using more carrots and less sticks if it really cares about the welfare of Australians. Better Access allows clinicians to set up practices in locations in which centre based services would never go, as the population base is too small or too remote. Taking money out of Better Access is taking money away from rural and remote Australians.

(h) the impact of online services for people with a mental illness, with particular regard to those living in rural and remote locations and other hard to reach groups

In many rural and remote areas, access to the internet is significantly limited. This is both by the speed of the internet available, and the costs of maintaining a computer and internet account. Specifically, a trend to online services will disadvantage those consumers who lack the resources and literacy to access computers. There is also the question of how culturally appropriate online services would be, especially for Indigenous communities.

(j) any other related matter.

The requirement for a consumer to be reviewed by their GP after six sessions is onerous and in some cases impossible for people living in rural and remote Australia. In some areas people can wait up to 3 months for a 15 minute appointment with their doctor, and often not the doctor of their choice, just the first one to have an available timeslot. This means that consumers are having their treatment interrupted as they wait for

review. This is detrimental to the consumer as a pause in treatment means therapeutic gains may be lost, rapport diminished, both of which take time to recover.

What is also concerning is the way in which the Independent Mental Health Expert Working Group was established and operates. What is disturbing about this is that both Patrick McGorry and Ian Hickie, both members of this committee, benefit financially from the reduction in Better Access funding, as this money is to be channelled into their own pet project: Headspace. Surely this is a conflict of interests? It appears, looking in from the outside, that the previous group was removed in order to install a more compliant bunch, ready to agree or at least not challenge the governments flawed policy.

Thank you for your consideration.

A rural psychologist