6th July 2011

Dr. Cal Paterson
Clinical Psychologist

I wish to submit information and comment to the senate enquiry in the Commonwealth funding and administration of mental health services. In particular, my submission relates to the following terms of reference:

> (b) changes to the Better Access Initiative, including:
> (ii) the rationalisation of allied health treatment sessions,
> (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.
> (e) mental health workforce issues, including:
> (i) the two-tiered Medicare rebate system for psychologists,
> (ii) workforce qualifications and training of psychologists, and
> (iii) workforce shortages.
> (f) the adequacy of mental health funding and services for disadvantaged groups, including:
> (iii) people with disabilities.

I will address each of these areas in turn.

1. Changes to the Better Access initiative

The primary effect of these changes has been to reduce the maximum number of sessions an individual may receive from 18 down to 10. The department of Health and Ageing released a Fact Sheet in May 2011 titled: "Cap Allied Mental Health Services". This release included the following observations:

- *"Almost three quarters of people who received an allied mental health service after a GP Mental Health Treatment Plan only needed between one and six services."*
- *"87 per cent of current Better Access users receive between one and ten sessions, and will be unaffected by the new cap."*
- *"Given the tight fiscal environment we* [the government] *have a responsibility to ensure that our investments are appropriately targeted to ensure maximum value."*

If this was the data that formed the basis of the reduction in allied health services that can be claimed via medicare, then three grave errors have been made:

a. It is incorrect to conclude that almost 75% of people who attend Psychological consultations require fewer than six sessions. If 75% of people made fewer than six claims for an allied health service under medicare, this indicates that the Better Access scheme has been poorly targeted, and that there are problems in the workforce providing these services. Of the Better Access patients I have seen since the scheme

began, around half have ended up attending more than the twelve sessions they can claim under medicare. Approximately one quarter of the referrals I receive are for individuals who have attended psychology sessions with medicare assistance in the past, with another practitioner. Most of these individuals either ceased treatment due to lack of progress, or were dissatisfied with the service they received for one reason or another. The review of Better Access did not consider why so few individuals accessed all twelve of their sessions, nor did it consider whether individuals obtained any benefit from such a truncated treatment process.

b. It is dangerous to ignore the minority of people with mental illness who do access twelve or more sessions, and to focus on the majority of people, who claim ten or fewer sessions via medicare per year. This minority are typically the individuals with more severe, complex, or co-morbid conditions, who are in the greatest need. If these individuals are better served by the ATAPS scheme or other public mental health services, why are they choosing to access Clinical Psychologists in private practice, given the latter option usually costs more? This was not considered prior to the capping of of Allied Health Services. The capping of sessions to ten, effectively targets the most vulnerable minority for exclusion from the services they require. These individuals are typically less able to afford sessions without the assistance of medicare. These individuals do not present the severity of disability that warrants their eligibility for public mental health services, which are prioritized for people at risk of harm to self or others. Lastly, this minority is poorly served by the ATAPS scheme, which provides an inadequate standard of intervention for an individual with complex or treatment-resistant issues. Many of these people seek Clinical Psychology services after completing or partially completing ATAPS treatment.

c. It is negligent to treat all medicare-registered allied health providers as equivalent, or to assume that they provide the same service. This assumption underlies the way that the services have been cut, i.e. by cutting the number of services all people can access, regardless of their circumstances, and regardless of the nature of the services they would have received. No attention has been paid to the heterogeneity of the mental health workforce, especially in terms of professional standards and level/ specificity of training among Psychologists. No other medicare item seems to be applicable to such a diverse and largely untrained cohort of service providers as those in the Better Access Scheme. It would represent a gross waste of expertise to exclude highly-trained mental health professionals such as Clinical Psychologists from a scheme alongside other service providers without the same standard of expertise.

2. Mental health workforce issues

The inclusion of all registered Psychologists in the Better Access scheme has created an unprecedented dilution of a sector of health service provision, in which individuals who are not trained to provide mental health services are nevertheless able to register and provide medicare-claimable services to members of the general population, without any formal oversight of the quality or efficacy of services they might provide. This is akin to giving prescribing rights to all registered nurses overnight. The result has been an influx of untrained, inexperienced but fully registered Psychologists into the Mental Health sector, in the precariously under-regulated environment of private practice. At the moment, for example, it is possible for a Psychologist trained only in Organizational theory or Research methodology, to register and provide mental health services via medicare. In general, the majority of the Psychologists who now provide mental health services via medicare have an

inadequate level of accredited mental health training, and it is therefore unsurprising that so few (less than 13%) of individuals who seek treatment for mental illness do not complete their treatment, as evidenced by the low number of people who go on to claim all twelve of their referred sessions back from Medicare. If services must be cut, and the cut is to be made to the area of least value, then this cut should apply to area of the sector in which the least amount of training and expertise in the area of mental health treatment can be demonstrated. Access to Clinical Psychologists via Medicare should not be restricted, since this group of providers is specifically trained to provide services in the mental health area.

I further propose that new telemedicine item numbers be extended to include Clinical Psychology Services, in order to address the problem of limited access to mental health services in rural and remote areas.

3. *The adequacy of mental health funding and services for disadvantaged groups, including people with disabilities*.

In addition to the minority of people with complex or treatment-resistant mental illness who are not eligible for acute or community-based mental health services, for whom the Better Access scheme was designed, there is another minority who have benefited enormously to date from the Better Access scheme, who will be substantially disadvantaged by its reduction: individuals with intellectual or developmental delay. The incidence of mental illness among this population is far higher than in the general population, and these people are routinely excluded from most mental health services due to their disability. However, the majority of people with a disability have a mild or borderline level of delay, and are suitable for mental health treatments such as cognitive and behaviour therapy. The Better Access scheme had achieved its objective very well for this population, making specialized mental health treatment financially and practically accessible to many in this group for the first time. The impact of the cut to the Better Access scheme on this group highlights the lack of care taken by policy-makers in planning the cut: no consideration has been paid to the different types of people who access mental health services, and their different levels of need.

Conclusion

Not all individuals who receive medicare rebates under the Better access scheme are the same, and it is a mistake to plan for them en masse. Not all service providers registered to offer services via the Better Access Scheme are the same, and it is a mistake to treat them as such. If mental health services in Australia are to be rationalized, then care must be take to do so in a way that does not dangerously disadvantage the core minority who need these services the most. To do so is to 'throw the baby out with the bathwater'. A more considered, and strategic restructure, which takes into account the different needs of individuals accessing mental health services, as well as recognizing the disparities in qualifiations among mental health service providers, will ensure that the scheme can reach the people for whom it was originally intended, and offer them services that will really make a lasting difference in their lives.