AIM: To discuss the negative impact of cutbacks to Better Access on people who use this service, with particular relation to the reduction of sessions available with allied health professionals. The following Terms of Reference are addressed:

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

PERSONAL PERSPECTIVE: I have suffered with serious and chronic mental health problems for 14 years and rely on Better Access for successful treatment. I am currently a PhD candidate in Fine Art, where my research involves reading firsthand accounts of peoples' experiences with mental illness. Most of the information contained in this document is founded on my own experience and the experiences of others with mental illness as told by them. However, I cannot assume to speak for all, and firmly believe a wide variety of people with firsthand experience of mental illness must be included in policy-making regarding the funding and administration of mental health services to ensure the most humane and effective outcomes possible.

PLEASE NOTE: If necessary I am willing to meet with the Senate Committee in person to address these issues in greater detail, and/or provide further information.

RECOMMENDATIONS:

- Maintain the current maximum of 18 sessions available with allied health professionals through Better Access
- Remove compulsory review by the referring doctor after just six sessions, in favour of a 12-month referral
- Consider providing additional sessions with allied health professionals for people with severe and persistent disorders requiring psychological treatment
- Consider addressing issues of equity and financial viability of Better Access from within the established Medicare framework, without negatively impacting on treatment for those who need it

RATIONALISATIONS: Rationalisations are explained in detail on pages 3-12. Key arguments can be summarised as follows:

- Individual sessions with a psychologist are the most important aspect of my mental healthcare, and the key to recovery and rehabilitation. Psychological services must be readily available for people in need to improve living standards and recovery rates for people with mental illness, including severe illnesses.
- There is a great need for non-pharmacological treatments for mental illness, especially for people who experience severe and dangerous side-effects (such as myself). Medication can lead to serious physical health problems so people must be given evidence-based treatment alternatives that cause no harm. Allied health professionals are able to offer such an alternative.
- Better Access aids in suicide prevention. People at risk should be allowed access to the therapist they know and trust regardless of how many sessions they have used in a calendar year. This will help reduce suicides and hospitalisations, which will also reduce costs to the taxpayer on acute care.
- Psychologists and psychiatrists provide different services so it is useless to force people who need more than 10 sessions with a psychologist into psychiatric care. They are not a suitable replacement for people needing more than 10

sessions with a psychologist. They will also cost the taxpayer considerably more.

- People with severe mental illness must not be excluded from Better Access by capping sessions at 10. It is difficult to find effective treatment for chronic mental illness and Better Access has solved this problem for many. People who receive effective treatment through Better Access must not have it taken away.
- The six-session review process is a barrier to continuous and effective treatment. It is unrealistic to expect people in extreme psychological distress to count sessions and co-ordinate referrals. It is anxiety provoking and a waste of money.
- Mental health policy must be based on evidence-based research that leads to recovery. 10 sessions with a psychologist are not sufficient to fulfill evidence-based psychological methods. A person using only 10 sessions or less is more likely to experience relapse, causing greater long-term expense to the Government.
- De-pathologizing mental illness is an important aspect of recovery. Normalising symptoms can lead to decreased psychological distress. Allied health professionals can play a key role in achieving this mindset.
- A reduction in sessions could hinder my recovery and rehabilitation, keeping me reliant on DSP for longer than necessary. This delay in recovery would be more likely for someone who has been receiving treatment for less time. Reducing sessions may have an added cost to the taxpayer by prolonging reliance on DSP and other sickness benefits.
- The 10-session cap discriminates against people with a disorder that requires long-term psychotherapy as primary treatment. Caps should be based on clinical need, not an arbitrary treatment length generalised to fit all conditions. Different mental illnesses require different treatment. This is especially so for illness that results from trauma, where the underlying cause must be addressed in therapy to prevent recurring symptoms.
- Some of the most disadvantaged people in society rely on Better Access. Blanket cutbacks go against the Government's aim of developing equity in mental healthcare. Disadvantaged people receiving treatment must not have it reduced.
- To create equity between physical and mental healthcare psychological services of sufficient length must be accessible through the Medicare system, which has already proven itself highly effective in providing quality physical healthcare to most Australians.
- Session reductions will mean only affluent Australians will be able to complete treatment length that provides lasting benefits. This will likely lead to more relapses for people with less financial resources.
- ATAPS is an unsuitable replacement for Better Access for anyone who has already established a relationship with a therapist they trust. Switching programs would significantly hinder progress. Better Access facilitates continuity of care, whereas ATAPS does not. Continuity of care is essential for effective treatment of chronic conditions.
- ATAPS should be reserved for people who do not suit treatment through Better Access, not be forced to handle the influx of disadvantaged people who will be excluded from Better Access due to cutbacks.
- ATAPS is a program with limited funding. If funding runs out people are left without treatment. This is unacceptable in an area of healthcare where access to treatment can be a matter of life or death.

PERSONAL BACKGROUND

Now in my early 30s, ***I have struggled with anxiety and depression since I was a teenager. Symptoms have ranged from mild to severe, and included self-harming and suicidal behaviours.*** This has caused significant disability, meaning I have relied on Government pension for a large portion of my adult life. Recently I have begun to earn some income outside of this, which I mostly attribute to successful psychological treatment. However, I am still on part DSP and in a low-income bracket.

Over the years I have received a wide range of treatments, and needed two periods of hospitalisation. I have tried almost everything (CBT, MBCT, DBT, ACT, psychodynamic therapy, psychotherapy, and over 15 psychiatric medications)! I have also taken an active role in educating myself about mental illness and its treatments. ***This has given me a wealth of experiential insight into the different ways treatments work and why,*** and some understanding of what it is like to navigate the mental health system.

Most psychiatrists believe I need medication (I have seen 5 over the years), but it causes me significant problems, such as increased agitation, suicidal ideation, sleep difficulties, dramatic mood swings, and even the potentially fatal serotonin syndrome, to name but a few. Therefore ***medication is a highly unreliable and potentially dangerous treatment option.***

WHAT HAS WORKED FOR ME

PSYCHOLOGICAL TREATMENTS: Psychoeducation (usually in groups) and regular individual sessions with a clinical psychologist. The most effective skills based treatment has been Dialectical Behaviour Therapy (a 12-month course), which armed me with skills to cope with my condition. ***I now rely on ongoing individual sessions with a highly qualified psychologist, and consider this treatment the key to my recovery, rehabilitation, and relapse prevention.***

MEDICAL TREATMENTS: My current psychiatrist manages my medication and is responsible for referrals to psychological services. From years of trial and error we have determined that ***anti-depressants, mood stabilizers, and anti-psychotics are unsuitable due to harmful side-effects***. Benzodiazapines are used in a careful and controlled manner to manage my daily anxiety. I take thyroid medication and vitamins to counteract deficiencies that affect my psychological wellbeing. This is monitored by my GP. ***Better Access has facilitated excellent collaborative care.***

FINANCIAL NEED FOR BETTER ACCESS: DBT (and other skills groups) are covered by private health insurance (paid for by my parents). Individual sessions with a psychologist are provided through Better Access. ***Without Medicare rebates I would not be able to afford this treatment.*** My psychologist charges me a reduced rate of $130, leaving me only $11 out-of-pocket per session. Private health insurance covers only $38 per session, with a max of 7 per annum. This does not come close to meeting my needs. ***As someone who relies almost solely on psychological treatment, 10 Medicare rebated sessions per year will be grossly insufficient, especially in light of my low-income***. Although my parents pay for my private health insurance, they are far from wealthy and cannot offer more financial assistance. We maintain my private health insurance because the public mental health system alone cannot meet my needs—a significant inequity which must be addressed for those who cannot attain private health insurance. Even so, ***Better Access has significantly increased the quality of treatment available to me.***

TERMS OF REFERENCE

b) changes to the Better Access Initiative,

BETTER ACCESS HAS BEEN INTEGRAL TO MY MENTAL HEALTHCARE, AND THE MENTAL HEALTH CARE OF MANY AUSTRALIANS: It has brought me great anxiety knowing sessions available with my psychologist will be reduced. Online I have met a number of people with severe and persistent mental health problems who also rely on Better Access to survive. While I acknowledge that Better Access is not reaching as many people of disadvantage as it could, this does not mean that it does not reach many of us, nor does it justify a reduction in service to those who need it. ***It is difficult to find effective treatment for chronic mental illness. Therefore any changes to funding must not interfere with people already receiving effective treatment.*** It is for people like these that I write this submission. Many people in this position would not be able to speak out for themselves as they are simply struggling to get through the day. In my own case, it is possible for me to speak openly about this difficult topic because of the effective treatment I have received through Better Access. A few years ago I doubt I would have been capable of this endeavour.

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

THE IMPORTANCE OF GPs WITH MENTAL HEALTH TRAINING: When I was first diagnosed with clinical depression as a teenager I lived in regional Victoria. I received treatment from a GP who had specialist training in mental health. At this point ***my GP was the only option for me to receive assistance.*** With her support I successfully completed VCE and went on to Uni the following year. I didn't need further treatment for another 3 years. ***The role GPs play in mental healthcare must be adequately acknowledged so their services can be improved for people who have no access to mental healthcare*** other than through their GP, which is often the case outside of capital cities.

(ii) the rationalisation of allied health treatment sessions,

SOCIAL WORKERS AND OCCUPATIONAL THERAPISTS: I do not have personal experience with social workers or occupational therapists. However I still advocate for their ongoing inclusion in the Better Access scheme because ***no single treatment works for everyone, and therefore a number of options must be available for people in need***.

THE VALUABLE ROLE OF PSYCHOLOGISTS IN MENTAL HEALTHCARE: Psychologists provide a diverse range of services for people experiencing mental illness. Their training is often dedicated to the treatment of mental illness through non-invasive and evidence-based means. For me, psychologists play two fundamental roles in my mental healthcare: 1) To teach me skills I can use outside of therapy to successfully manage symptoms of mental illness in my daily life; and 2) to provide psychotherapy that addresses past trauma and psychological distress. Through this, ***psychologists have helped significantly decrease the impact of mental illness on my daily functioning***, making me increasingly more self-reliant. I believe this should be the ultimate goal of mental healthcare and psychologists must be duly valued in their ability to provide this. ***I consider individual sessions with a psychologist the most important aspect of my mental healthcare.***

THE DIFFERENCE BETWEEN PSYCHOLOGISTS AND PSYCHIATRISTS: There appears to be a misconception that psychiatrists exclusively treat severe and chronic mental illness, while psychologists are only for less serious or short-term concerns. This is not true. In my own case I need the ongoing support of both a psychologist and a psychiatrist. ***Additional sessions with my psychiatrist cannot replace sessions with my psychologist because they perform different roles. My psychiatrist manages medication; my psychologist provides therapy.*** This arrangement works well, but also means it is more useful to have more sessions with a psychologist than psychiatrist (as opposed to the new 10/50 arrangement the Government has proposed). While some psychiatrists do offer talk therapy, in my experience it is not as effective as that provided by a psychologist. It is also unfair to force someone receiving successful treatment from a psychologist alone to switch to psychiatric care. This will likely involve the introduction of medication, which should be avoided unless necessary. ***To say that people who need more than 10 sessions with a psychologist can simply see a psychiatrist reveals a gross misunderstanding of treatments for mental illness and the diverse needs of patients.*** The Government must not reinforce such misinformation.

THE NEED FOR NON-PHARMACOLOGICAL TREATMENT FOR MENTAL ILLNESS: Medication does not work for everyone. For some, it can take many years to find a medication that works. For others, ***medication can cause dangerous side-effects*** that render them useless even in cases of severe mental illness. It must be reserved for use in cases where people cannot get well without it. My own case is a good example of the need for non-pharmacological treatment alternatives that work, and how specialist psychologists can provide this:

THE HARMFUL ROLE OF MEDICATION IN MY OWN CASE: Reflecting on my own case I firmly believe ***medication has contributed to the length of my disability***. The side-effects I experience often look identical to a worsening of psychiatric symptoms, which can be difficult for even some psychiatrists to detect. At one point ***I was on anti-depressants for years before a psychiatrist correctly diagnosed what was believed to be symptoms of mental illness as side-effects of medication.*** Once off the medication I immediately became more stable, albeit quite depressed. We continued to trial a number of different medications but a similar scenario played out each time: ***each new medication destabilised my condition***. It became evident that with treatment from a psychologist my condition was manageable, but when sessions ran out (due to the Medicare rebate cap) symptoms became much worse.

SEROTONIN SYNDROME: A few years ago I was hospitalised during a Major Depressive episode. The psychiatrist I was appointed determined that such severe symptoms must be treated pharmacologically. However, ***the medications he prescribed resulted in serotonin syndrome,*** which was mistaken by nurses and doctors as a worsening of psychiatric symptoms. ***This could have been fatal had I not stopped the medication***. I suffered debilitating withdrawals for weeks. However, I do not believe this was the result of an individual psychiatrist's incompetence, but a reflection of the greater problem of pharmacological/biological interventions being privileged over all other treatment options in severe cases, even when a patient objects (as I did). This has significantly lengthened my period of disability, and interfered with me receiving the treatment that does work: sessions with a psychologist. ***This could be avoided if greater value was placed on the role of specialist psychologists in treating severe presentations of mental illness.***

THE ROLE OF PSYCHOLOGISTS IN THE DE-PATHOLOGIZATION OF MENTAL ILLNESS: Much of the stigma related to mental illness comes from the lack of recognition given to it being a normal aspect of human experience, albeit a highly distressing one. ***Psychologists have played a key role in teaching me to***

successfully navigate my life despite symptoms of mental illness, instead of trying to pathologize and get rid of the illness. Much of my treatment relates to "normalising" my experience. This is in opposition to the medicalisation of mental illness, which supposes that any state of mental ill-health is "abnormal". ***Normalising symptoms significantly decreases distress***, and I have read many accounts by people with a range of mental illnesses (from personality disorders, to depression, to schizophrenia, to bipolar disorder) who have also found this de-pathologization of mental illness to be an extremely important aspect of their recovery. For me, ***psychologists have played an important role in helping me achieve this mindset.***

(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,

PATIENTS REQUIRE SUFFICIENT TIME FOR GPS TO DEVISE MENTAL HEALTH PLANS: A person visiting a GP for the first time about their mental health concern must be given sufficient time to have their case carefully reviewed. This will allow for possible physical causes to be ruled out, and referrals to the most appropriate mental health services determined. If the current rebate has been reduced because GPs are not spending the necessary time to complete a competent MHP then ***measures must be taken to ensure GPs are providing adequate services, not reducing rebates and creating further barriers to patients receiving mental healthcare***. The ultimate goal of any changes to mental healthcare funding must be to improve services, not weaken them. Government policy and Medicare rebates must reflect this.

SIX-SESSION REVIEW PROCESS CREATES UNNECESSARY BARRIERS TO TREATMENT: People with mental health problems are notorious for missing appointments, lacking motivation, having anxiety attacks when seeing doctors etc. In light of this, people in need of psychological treatment must not have any additional barriers placed in the way of receiving treatment. This review process forces them to find additional time and money to return to their GP or psychiatrist for a second referral. This is not always easy, especially in remote or rural areas. ***Expecting people in psychological distress to count sessions or coordinate referrals is unrealistic***, it likely accounts for the number of people dropping out of treatment before the six-session mark. ***I have found the process unnecessary, limiting, anxiety provoking, and a waste of money.*** At times it gets in the way of progress. I strongly suggest that a referral to a psychologist be valid for a 12-month period without compulsory review. However, regular reports should still be sent to the referring doctor to ensure that treatment response is being closely monitored. ***Removing the need for these unnecessary reviews will ensure continuous patient care and in turn save taxpayer money.*** In my experience, psychologists do not encourage unnecessary sessions or over-reliance on their services, and ***specialist psychologists are often in a better position to determine adequate treatment length than the referring doctor.***

(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;

PEOPLE WITH MILD TO MODERATE MENTAL ILLNESS MUST NOT BE FORCED INTO PSYCHIATRIC CARE: Mild to moderate mental illnesses are those most likely to respond to psychological services alone. However, there is no evidence-based research to show that 10 sessions are sufficient to achieve wellness without relapse. The aim of mental healthcare must be to do the least harm to the patient, and to intervene early to prevent symptoms from worsening. ***Cutting treatment short may result in a worsening of symptoms, or force people into unnecessary psychiatric care. This may reduce their chances of getting well with the treatment most appropriate for their needs***. It also costs considerably more for the taxpayer and patient meaning additional sessions with a psychologist are far more economically viable than switching to a psychiatrist.

BETTER ACCESS DOES NOT EXCLUDE TREATMENT FOR SEVERE MENTAL ILLNESS: Cutbacks to Better Access unfairly excludes people with severe mental illness who receive adequate treatment through this scheme. ***Some 'severe mental illnesses' are still best treated by a psychologist alone, or with a psychologist as the primary caregiver.*** This is particularly so in cases such as mine where medications create worsened symptoms of mental illness. Such people should not be forced into team-based care. If a person with a severe mental illness feels Better Access is the best mode of service delivery ***they must not be excluded from receiving this treatment by capping Medicare rebated sessions at 10.***

IMPACT OF REDUCTION TO SESSIONS AVAILABLE ON MY PERSONAL TREATMENT: For 14-years I have been plagued with mental health problems, causing significant disability and disruption to my life. ***Over the past few years my quality of life has greatly improved with the ongoing support of my psychologist.*** I often use the full 18 sessions a year, sometimes more. This greater need for sessions is particularly important as I begin to participate more fully in life, which brings on further triggers and stressors (but will ultimately lead to faster rehabilitation). This is by far the most effective approach to rehabilitation and recovery I have found. I fear that ***this reduction in sessions may hinder my recovery and slow down the process of me becoming financially self-reliant—an added burden to the taxpayer that must be considered when reducing sessions to "cut-costs".***

DISCRIMINATION AGAINST PEOPLE WITH A MENTAL ILLNESS THAT PRIMARILY REQUIRES PSYCHOLOGICAL TREATMENT: People with disorders requiring long-term psychological treatment are being discriminated against by capping sessions at 10 across board. One example is Borderline Personality Disorder. ***It is imperative to provide adequate long-term and stable treatment to people with BPD because self-harming and suicide attempts are often high***, which can strain emergency services with a higher cost to the taxpayer than Better Access. Many such people need a chance to build up a long-term relationship with a therapist they trust. Even the current cap of 18 sessions is often too few for such patients. There are many other disorders that would also fit into this category. ***Caps should be based on clinical need, not an arbitrary measure of treatment length generalised to fit all mental disorders.***

MENTAL ILLNESS RESULTING FROM TRAUMA OFTEN REQUIRES LONG-TERM PSYCHOLOGICAL TREATMENT: If a person experiences trauma, particularly over a long time period (such as with child abuse or domestic violence), it is often expressed through symptoms of mental illness. If the cause of the symptoms—the trauma—is not adequately addressed then symptoms will likely recur. ***People who have suffered such trauma must be offered psychotherapy to treat the root of the illness. This cannot be done in a mere 10 sessions.*** More sessions must be available to such people to ensure the cause of the illness can be adequately addressed and recovery achieved.

BETTER ACCESS AIDS IN SUICIDE PREVENTION: My crisis management plan is an important aspect of suicide prevention. My psychologist plays a key role in this.

More often than not he is able to help ward off an ensuing episode of suicidality before it escalates. ***If my 10 sessions are up, my suicidal ideation increases, and I cannot afford treatment then what am I to do? The new Better Access scheme provides no provisions for such a scenario.*** My psychiatrist is not of use if the trigger is of psychological origin. Other mental healthcare professionals that do not understand the history behind my situation are of little help (in fact, they usually make matters worse). ***Expecting someone to trust a new professional at a time when they are most vulnerable is highly unrealistic.*** Provisions need to be made to ensure people in a state of crisis can access the professionals they know and trust. The additional six sessions in ‘exceptional circumstances’ did something of this and their removal will greatly increase suicide risk for someone like me. ***Reinstating the full 18 sessions is imperative for suicide prevention***. ***I also recommend that people at risk are allowed even more sessions if needed.*** This will also help keep people out of hospital, which in itself can cause long-term psychological distress. Keeping people out of hospital also reduces costs to the taxpayer.

RESPONSIBILITY OF THE GOVERNMENT TO PROVIDE TREATMENT LENGTH COMMENSURATE WITH EVIDENCE-BASE: To the best of my knowledge 10 sessions are not sufficient to fulfill evidence-based treatments (such as CBT or DBT), nor are they enough to help someone successfully recover from a chronic mental illness. Therefore it makes no sense to cap sessions at 10. ***Mental health policy must be based on evidenced-based treatments, not arbitrary numbers that suit the budget’s bottom line.*** It is unethical for a Government to provide sub-standard treatment lengths to people in need. Such a practice would be unacceptable in physical healthcare, and must not be accepted in mental healthcare as the norm.

THE RIGHT FOR PEOPLE TO CHOOSE THE TREATMENT THAT CAUSES LEAST HARM: The reduction in sessions available with a psychologist will make it much harder for most people to access a full-course of psychological treatment. The benefit of psychological treatment is that, unlike medication, it has no negative impact on a person’s physical health. ***Medication can cause a number of side-effects that put stress on the physical body. These physical stressors can lead to serious health conditions*** such as diabetes. People must be given the option of choosing the treatment that causes the least harm to the body, which in turn prevents further spending on physical healthcare.

ISSUES OF EQUITY

The Government claims cutbacks to Better Access have been instated to redirect funding to people in greater need. While I applaud this motivation, I believe ***the cutbacks will in fact leave many people in great need without adequate treatment***. The following issues need to be addressed to ensure greater equity in mental healthcare:

CUTBACKS AFFECT ALL PEOPLE USING THIS SERVICE, INCLUDING THE DISADVANTAGED: Although the current data available on Better Access shows that the highest amount of money is going towards people with the least disadvantage, it also shows that ***some of the money is going towards people who are most disadvantaged. However, the cutbacks have been issued across board***—they will affect all people receiving treatment. All people I personally know who rely on these additional sessions are not wealthy and need rebates to afford treatment. Many are on pensions. Some are from rural/remote areas. Many of these people will not be eligible for treatment through the Government’s new initiatives. ***It is unacceptable to make it even harder for people of disadvantage to receive adequate treatment.***

WHY AREN'T THE DISADVANTAGED USING BETTER ACCESS?: To adequately address issues of equity in Better Access ***there needs to be more rigorous investigation into why people of disadvantage are using it less.*** Changes in service need to be based on facts, not assumptions. This is especially important, as Better Access has already proven itself to be a highly successful and cost-effective mode of service delivery. Therefore, ***finding ways to integrate more socio-economically disadvantaged people into this program is likely to have better clinical outcomes at a lower cost to the taxpayer.***

PEOPLE IN NEED USE BETTER ACCESS: In my own case I need Better Access. I could not afford individual sessions with a psychologist without it, and at the same time I need individual sessions with a psychologist to function. It alarms me to hear the Government claim to have redirected funds to people in greater need, because without it I don't know what I would do. As someone who has had chronic mental health problems for so long, which have caused significant disability, why would the Government deem me unworthy or not in need of treatment? And what about the many other people who rely on Better Access to survive? ***There are many people using Better Access who are in great need and they must not be overlooked when making changes to this initiative.*** Changes must not prevent people in need from receiving adequate treatment.

EQUITY BETWEEN ACCESS TO PHYSICAL AND MENTAL HEALTH: When I've had problems with my physical health I have never faced significant barriers to treatment. It has always been available when needed, thanks to Medicare. This is obviously an indication of how well the Medicare system works. Therefore, in order to create equity between physical and mental healthcare, ***it makes sense to ensure a range of psychological services are available on the same system that has already proven itself to work for physical healthcare.***

ISSUES OF EQUITY BASED ON CLINICAL NEED: When it comes to issues of mental health, someone who has a moderate income but requires psychotherapy 52 times per year will have more difficulty accessing treatment than someone who has a low income but only needs 12 sessions per year. Socio-economic disadvantage is not the only factor that needs to be taken into account when thinking of equity issues in mental healthcare. ***Clinical need for treatment must be an integral factor to consider when determining mental health policy, not just socio-economic disadvantage***. There needs to be more thought put into the wide range of disorders Better Access caters for instead of lumping all mental illness into the same category, and assuming the same treatment will work for all.

CUTBACKS WILL MEAN ONLY THE WEALTHY CAN RECEIVE FULL TREATMENT LENGTH: Research shows approximately 15-25 sessions are required to make lasting changes in a person's mental health. The new cap of 10 sessions will mean only affluent Australian's will be able to receive the full treatment length. This means ***people with less money will not be able to complete treatment.*** These cutbacks appear to discriminate against the poor by ensuring they do not gain lasting benefits due to inadequate treatment length. ***Many people in the middle-income bracket would also find it difficult to afford the full length of psychological treatment out-of-pocket.***

INCREASING FINANCIAL VIABILITY OF BETTER ACCESS BY ADDRESSING ISSUES OF EQUITY FROM WITHIN THE MEDICARE FRAMEWORK

Better Access has already proven itself to be a highly successful and cost-effective mode of service delivery. Therefore ***any changes to the program must <u>increase</u> its effectiveness***, not decrease it. While I personally believe that mental healthcare should be easily available to all people that need it, I also understand that the Government must also make decisions based on financial viability. It is my proposition that issues of equity and financial viability are addressed from within the Better Access/Medicare framework, ***in such a way that people in need are not left without adequate treatment (as the new reduction in sessions will do).***

EXAMPLES OF HOW THIS MIGHT WORK:

REBATE AMOUNT BASED ON FINANCIAL NEED: The PBS provides different levels of funding based on a person's financial need. That is, PBS prescriptions are normally $34.20, but for people with concession entitlements they cost only $5.60. A similar rule could be applied to Better Access: ***people with concession entitlements could receive higher rebates if bulk-billed. This would remove the gap fee for people who cannot afford it.*** Others could be given a lower standard rebate. This will remove the barrier for treatment that may be created by some psychologists needing to charge gap fees, while people who can afford to pay a gap continue to do so, thus limiting the cost to the taxpayer.

SESSION CAPS BASED ON DIAGNOSTIC/CLINICAL NEED: Rebate level and session caps could be determined on clinical need. For instance, someone with a diagnosis of a BPD or PTSD (requiring psychological treatment) could receive more Medicare rebated sessions than someone without. This would ensure people are able to receive the right treatment for their needs. ***Such measures could be used to reduce discrimination against people with disorders that require long-term psychological treatment***, including those who are not entitled to a 'concession rebate' but could not afford the full length of treatment necessary for their condition. Care would need to be taken to ensure such a measure was implemented fairly.

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

THE UNSUITABILITY OF ATAPS IN MY OWN CASE: As a person on a low-income who is already receiving effective treatment through Better Access, I do not wish to be forced into the ATAPS program (if I am even eligible, of which I do not know). ***I already have an established relationship with a therapist that works***. There is no sense in forcing me to change programs*.* There are many people who will be in a similar position to me. ATAPS is grossly inadequate in such cases. ***The additional time taken to establish a working relationship with a new therapist will result in unnecessary costs to the taxpayer and an extended period of disability.*** Measures must be taken to ensure such people do not lose access to the professional they already trust.

ATAPS SHOULD BE RESERVED FOR PEOPLE WHO CANNOT RECEIVE TREATMENT THROUGH BETTER ACCESS: The significant reduction to Better Access will mean disadvantaged people who currently receive treatment through Better Access (or who could potentially do so) will be forced to use ATAPS. ***This will put unnecessary pressure on the ATAPS system, which should be reserved for people whose needs are not met by Better Access.*** This might be acceptable if there was adequate data to prove that new funds directed to ATAPS will be sufficient to service all people in need. However, considering the extent of the cutbacks to Better Access I find it highly unlikely it will. It makes no sense to clog up ATAPS with people who can use Better Access, which will either prevent people who need ATAPS from receiving treatment, or cost the taxpayer more per person to provide treatment.

LIMITED FUNDING FOR ATAPS CREATES BARRIERS TO TREATMENT: Quite simply, ATAPS is a scheme with limited funding. ***If funding runs out, then people are left without treatment.*** This is not a suitable approach to the treatment of mental illness. ***Treatment must always be available when needed, because it can be a case of life or death.*** There must be provisions in place to ensure this does not occur, or unnecessary strain will be put on more costly emergency services (such as hospitalisation).

BETTER ACCESS FACILITATES CONTINUITY OF CARE WHEREAS ATAPS CANNOT: In mental healthcare there are no definitive answers, meaning even the same disorder can have a number of possible causes and treatments. This makes ***a professional who knows a person over a long period of time much more likely to understands how best to provide treatment.*** It can also take many years to build trust in a therapist to facilitate real healing. I have faced this issue of continuity of care, and experienced the dire consequences that can result. The program of DBT I undertook exited patients from the program after 12-months, regardless of mental state. ***This sudden severing of the therapeutic relationship left me unable to effectively cope with a stressful life event that occurred at this same time. This resulted in hospitalisation.*** I improved once a relationship with my previous therapist was re-established, and have continued to improve in the years since due to the stable therapeutic relationship we have. This continuity of care has played a huge role in my rehabilitation. This type of therapeutic relationship cannot be developed in any program that has an expiry date, like ATAPS. ***Continuity of care is of utmost importance for people with severe and persistent mental health problems who need treatment over a long period of time.*** Measures must be taken to ensure it is possible for anyone in need of mental healthcare to receive continuity of care.

FLEXIBILITY OF BETTER ACCESS TO INCREASE SESSIONS BEYOND MEDICARE CAP: There have been times when I have required more than 18 sessions a year with my psychologist. At these times he has offered me additional sessions at a significantly reduced rate. I have also heard of others being offered sessions pro bono. Although this scenario is not ideal (i.e. I believe psychologists should be adequately remunerated for their services, and sometimes feel too anxious to take up such an offer on principal), this kind of flexibility is highly valuable and to my knowledge not possible in a program like ATAPS.

QUALITY OF CARE: BETTER ACCESS VS. ATAPS: Better Access has provided me with a much higher quality of care than was available to me before it was introduced. My current psychologist has far more qualifications and expertise than any psychologist I have seen through other public services. ***The introduction of Better Access is the first time I have seen people with less financial resources able to receive the same quality service as people with more money.*** I fear that taking money from Better Access and investing it in ATAPS will be moving the quality of mental healthcare for the disadvantaged in the wrong direction.

MEASURES NEEDED TO ENSURE QUALITY OF CARE THROUGH ATAPS: Many years ago I was provided 2 years of weekly sessions with a psychologist through a NGO affiliated with Centrelink. It is now very clear to me that ***the quality of treatment was in no way comparable to that I receive through Better Access.*** This psychologist seemed to have little experience, and her understanding of mental illness and its treatments were rudimentary. ***I considered sessions with her somewhat pointless***—merely a means to receive financial support from Centrelink.

I still found it necessary to seek treatment elsewhere, ***whereas now I consider sessions with my current psychologist to be the most effective treatment I receive.*** This reflects the significant difference between sessions from psychologist to psychologist, and the need for psychologists with more experience and/or expertise to treat complex mental health disorders***. It is my concern that ATAPS will be used to fund psychologists similar to the one I saw through Centrelink, which is a waste of patient time and taxpayer money.*** Therefore measures must be taken to ensure psychologists providing treatment through ATAPS are able to provide high quality services to the people in most need.

BETTER ACCESS ALLOWS FOR BETTER EXCHANGE OF INFORMATION AMONGST PEERS THAN ATAPS: When it comes to issues of mental health often we trust our peers more than our doctors. ***The Better Access scheme allows peers to pass on information between one another to help find the right therapist for their needs***. This can be more effective than having one randomly allocated through a doctor, mental health clinic, Centrelink service etc. In my experience this has a more positive outcome for the person in need of treatment because their ***peers often have a deeper understanding of their needs than a doctor who has met them in a time-pressured scenario***, as is often the case in the public mental health system. ATAPS will force people to see specific practitioners instead of allowing them choose who they would like to see. This may decrease the effectiveness of treatment.