

"It is not at all clear that the government has any clear values and principles which guide its health policies, e.g. universality, equity, efficiency – Without such guiding principles health policy will continue to be subject to managerial fads, responses to hot-button issues and the placating of noisy and selfish special interests."

John Menadue Presentation at 11th National Rural Health Conference MARCH 23, 2011

As a semi-retired senior psychologist, working part time in two regional practices, I would first like to acknowledge the significance of the commitment in the health budget to increase funding for certain mental health services that have had a good take-up by particular consumer groups, such as headspace and the ATAPS program. I am writing, however, to express my deep concern regarding the proposed reduction to the maximum number of rebatable sessions available to people accessing mental health care when referred by GP's or psychiatrists to psychologists and other allied health professionals providing treatment under the Better Access to Mental Health Care initiative. The Better Access initiative is the only program intended to increase access to mental health treatment for all Australians suffering high prevalence mental disorders, regardless of age, ethnicity, diagnostic or socio-economic status. Informed by several decades of regional practice, I strongly believe that the decision to reduce the maximum number of rebated sessions allowable, from 18 to 10 sessions, would have unforeseen and dire indirect consequences for our nation's mental health standing, by directly impacting the prognosis for many of the more damaged and vulnerable people in Australian society who would no longer be able to access effective mental health treatment of their choice.

The main rationale accompanying this budgetary measure appears to be that these cuts will save funds which will be re-directed into other mental health services. While additional funding is undoubtedly warranted for these other, more narrowly focused mental health services, "robbing Peter to pay Paul" is always short-sighted economy in terms of ensuring similar or better outcomes. Regarding medical costs alone, over the last four decades extensive research has accrued demonstrating that the delivery of psychological services offsets the cost of medical care (Sanchez & Turner, 2003). There is also good evidence that psychological treatment for severe mental illness is more effective over the longer term than medication in decreasing hospital admissions. (Barlow & Durand 2011). Furthermore, "As many as 60 – 70% of GP visits either stem from psychological distress or at least are exacerbated by psychological or behavioural factors" (Duncan, Miller & Sparks, 2004). Examples of the link between psychological / behavioural factors and chronic medical conditions, include smoking-related terminal illness and obesity-related diabetes. Given ever-burgeoning medicare costs, achieving illusory "savings" by reducing the cap from 18 to 10, on the maximum number of medicare rebatable services under the Better Access initiative, simply does not make economic sense.

Summary

This senate submission contributes a regional psychologist's perspective as "practice based evidence", to others' academic research in addressing the invalid assumptions that appear to have formed the rationale used to justify these mental health budget savings. Included, as an appendix, is a sample of petitioner's comments including many appeals from consumers and family members directly impacted by the proposed Better Access cuts. I aim to address the following aspects of the rationale provided for the proposed reduction to the maximum number of rebatable sessions available to people accessing mental health care when referred by GP's or psychiatrists to psychologists and other allied health professionals providing treatment under the Better Access to Mental Health Care initiative:

- * **Preamble – What price mental health?**
- * **The confusion between the average number of services actually used, and the average number optimally required.**
- * **The assumption that hard to reach and vulnerable groups will somehow be better serviced by these budgetary cuts**
- * **The assertion that the Better Access initiative should be re-focused to mostly target consumers with milder symptom severity.**
- * **The belief that those who are affected will be able to access psychiatric services when needed.**
- * **The assumption that those who are affected will be able to access other equally appropriate mental health services, including ATAPS.**
- * **Conclusion**
- * **Appendix – Petitioner's voices.**

Preamble – What price mental health?

The World Health Organisation defines mental health as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. This emphasis upon the readily overlooked psycho-social aspects of mental health, has obvious implications for the cost of mental disorder within society. When people cannot realize their own potential, cope with the normal stresses of life or work productively and are unable to make a contribution to their community, their families, workplaces and broader communities also shoulder the costs of mental illness. *“The National Survey of Mental Health and Wellbeing conducted in 2007 by the Australian Bureau of Statistics (ABS 2008a) estimated that 3.2 million Australians, or 20%, of the adult population experienced symptoms of a mental disorder in the 12 months before the survey.”* (AIHW 2010). In developed nations, mental illness ranks second in terms of causing disability and accounts for 27% of all disability costs, yet for many years, only 7% of Australia’s health budget has been directed to mental health. Furthermore, *“public surveys repeatedly show that mental health is the public’s most urgent health priority.”* (CPD fact sheet – Mental Health)

In response to Professor Ian Hickie’s article “Professional and bureaucratic interests the biggest threat to mental health reform” (Crikey archives Thursday, 24 July 2008) Dr Lesley Russell writes:

“... most people with mental illness go without needed services. Only 38% of adults and one quarter of children and young people experiencing a mental disorder seek assistance from a health service. In contrast, around 80% of people with a physical problem access care. Little is known about those who remain untreated, nor do we know about how many seek help, but are unable to access or afford appropriate assistance. However, the figures highlight that the potential demand for mental health care is high and is not being adequately met by any part of the health care system – by GPs, specialists, community-based care or the acute care system. Indeed, the more likely you are to need mental health services, the less likely you are to be able to access them. We would never allow this situation to be the case for people with cancer. Why is it acceptable for mental illness?”

The Commonwealth Government’s implementation of the Better Access Initiative has significantly increased universality and equity of access to mental health care by removing or greatly reducing the financial barrier to seeking psychological treatment. In the three years subsequent to the introduction of the Better Access Initiative in November 2006, Medicare data showed that over 2 million individual Australian’s suffering symptoms of mental disorder accepted GP referrals to psychologists under the program (APS June, 2011), with 262,144 (13%) of these people utilising more than ten psychology consultations. (APS June, 2011). Benefits paid for Medicare-subsidised mental health-related services provided by psychiatrists, GPs, psychologists and other allied health professionals totalled \$666 million in 2008-09. (AIHW 2010). To place this sum in a wider budgetary context, in 2006 COAG estimated that the total annual cost of mental illness in Australia was approximately \$20 billion. Dollar for dollar, if this same amount were spent on mental health, the cost to Australian tax-payers would have been greater than total defense expenditure in 2010 (\$19,799,000,000). What price mental health? Given the context of the broader cost to consumers of these “savings”, it seems doubtful that budgetary questions regarding either the cost effectiveness or the outcome efficacy of the Better Access initiative as it currently stands, can be meaningfully addressed when isolated from some basic considerations regarding the nature and treatment of mental ill-health, and listening – really listening – to consumer “voices”.

Fortunately, mental health treatment, when truly of “evidence based” quality and of sufficient duration and accessibility where and when consumers choose to use it, is remarkably cost effective. The recently released evaluation of the Better Access initiative, (Department of Health and Ageing, 2011), returned a resounding affirmative to the question as to whether this substantial investment in mental health is proving to be efficacious in terms of outcomes for Australian’s accessing psychological services through the initiative. Of the 2 million consumers who have used Better Access services Australia wide, it is difficult to imagine finding even one clear, genuine consumer voice unopposed to these cuts because it is impossible for consumers to envisage any possible rationale that would justify the reduction from 18 to 10 in the maximum number of services allowable to them. For psychologists who are providers for Better Access clients, the DoHA own evaluation data speaks for itself, unswayed by vested interests, invalid assumptions, or “the voice of powerful people”.

Executive summary

The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) initiative is successfully responding to low treatment rates for common mental disorders and improving outcomes for people with such disorders. Better Access consumers are not presenting with mild complaints. More than 90% have diagnoses of depression and/or anxiety (compared with 13% of the general population). More than 80% are experiencing high or very high levels of psychological distress (compared with 10% of the general population). The initiative is not just bolstering mental health care for those who were already using services. Around half of all Better Access consumers have no previous history of mental health care. Better Access consumers respond well to the care they receive through the initiative. Not only are they extremely satisfied with the skills of the providers they see and the quality of the treatment they are offered, but they also make statistically significant and clinically

meaningful gains when assessed by standardised mental health outcome measures. Many report that their symptoms reduce, their psychological distress diminishes, and their overall wellbeing improves. (DoHA 2011)

Despite the DoHA evaluation showing that the Better Access initiative is, in a sense, “overperforming” its original intention (in terms of providing Better Access to psychological services for more consumers and effectively treating more consumers with moderate to severe mental disorders than was anticipated), the government plans to almost halve consumers access to this treatment. Even with twelve services, the “exceptional circumstances” provision has been the only option to ensure relative continuity of care for many people who need it most.

Several invalid assumptions seem to have informed this budget measure. In my opinion, assumptions regarding the average number of treatment services optimally needed, the ease with which consumers are able to gain access to other services, the confusion between the impact of chronicity and severity on the nature and rapidity of recovery from mental illness, and confusion between the academic qualifications and the clinical skills required by providers, have each contributed misinformation to policy development. In regard to the latter, it is not my intention to elaborate here my concerns regarding the sad history of political maneuvering by “powerful voices” that led to the implementation in the first place of a two-tiered medicare rebate structure for psychologists under the previous government. Fortunately, consumers seem to be unaware of the controversy which has divided our profession. Personally, my practice has been less affected than that of most psychologists, as I am semi-retired, and no other service providers with whom I am contracted (ATAPS, WorkCover, VCT etc) discriminate between different specialties within the psychology profession. Ideologically however, I am appalled at the completely avoidable waste of hard-won mental health funding by the two-tier psychologists medicare structure. I would therefore like to add my voice to that of many other psychologists highlighting the fact that, within the medicare budget, substantial savings could be achieved simply by removing the difference between the completely non-evidence based, arbitrary, offensive and divisive higher tier “clinical psychology” rebate, without in any way disadvantaging the many psychologists who bulk bill disadvantaged clients in rural and regional areas. (Other equally courageous and perhaps more creatively procured savings could be secured by ceasing the taxpayer subsidization of those private health insurers that generously fund “homeopathy”, which is probably best described as non-science nonsense, while allowing as few as four rebates for psychology consultations). I am perplexed as to why the budget measure instead proposes removing the option of eight potentially life-saving services directly from consumers, and address the assumptions apparently underlying this decision as follows:

*** The confusion between the average number of services actually used, and the average optimally required.**

“Budget Measure: Cap Allied Health sessions to 10 from 12 – saving \$174.6 million over the next five years

Data shows that almost three-quarters of consumers who accessed allied health services under the Better Access initiative needed only between one and six services a year – not the twelve that are currently on offer. The average number of allied mental health services received after a GP Mental Health Treatment Plan is five.” National Mental Health Reform - Ministerial Statement.

Given the stigma, discrimination and stereotyping still surrounding mental illness, it takes great courage for most consumers to commit to mental health treatment, and it cannot be assumed that the average number of services optimally needed is necessarily even remotely equivalent to the average number of services actually used. Unfortunately therefore, policy decisions informed by such a convenient interpretation of the Better Access evaluation data, seems to reflect little more than ill-informed wishful thinking.

In accessing mental health services, each patient referred by a GP inevitably experiences at least some ambivalence in seeking help, even for relatively uncomplicated clinical presentations. Some may only reluctantly “follow doctor’s orders” and others may be pressured by partners or life circumstances to discontinue sessions prematurely. Decades of outcomes research in psychotherapy demonstrates that the most frequent total number of sessions per consumer is only one, - or, in other words, one single session is the modal number of services for all clients in therapy (Frank, 1990). However, for uncomplicated presentations, the minimum average optimum number of treatment sessions to ensure semi-robust recovery from depression or anxiety is closer to twenty services (APS, 2010).

A classic meta-analysis of 125 separate studies found that typically almost 50% of mental health clients drop out of treatment prematurely (Wierzbicki & Pekarik, 1993). Therefore, just as the “average” frequency of antibiotic dosages would be skewed to far less than optimal by the high incompleteness rate, so too is the average number of allied health services accessed by consumers under the Better Access initiative skewed to far less than optimal by the high incompleteness rate. Many consumers can be expected to drop out as soon as they start to experience their symptoms initially lifting (which frequently occurs after just one session), but when life stressors recur, often cannot then sustain an improvement. Moreover, while 60% – 65% of consumers can be expected to experience initial “symptomatic relief” (as against sustainable resilient recovery) within as few as one to seven services, 35% - 40% can be expected to need considerably longer (Howard, Kopte, Krause, & Orlinsky 1986).

*** The assertion that the Better Access initiative should be re-focused to mostly target consumers with milder symptom severity, as was originally intended**

"This adjustment also recognises that individuals requiring more than 10 allied mental health services sessions may be experiencing more severe symptoms and may not necessarily be ideally suited to treatment through a universal Medicare scheme like Better Access, but rather could benefit more through referral to more appropriate mental health services such as Medicare-subsidised psychiatrist consultations or state services for people with severe and debilitating mental illness."

National Mental Health Reform - Ministerial Statement.

As in all aspects of health policy, a focus upon early intervention and prevention makes both economic and humanitarian sense. The Better Access initiative was intended to treat "mild to moderate" high prevalence mental disorders on the reasonable assumption that this would provide early intervention and prevent untreated symptoms from worsening. Obviously this would be ideal, and had mental health historically attracted resources equivalent to those allocated for physical health, it may have even been a realistic ideal.

In my opinion, there may be several reasons why, clearly, *"Better Access consumers are not presenting with mild complaints"*. It could be that this partly reflects decades of neglect of mental health in Australia so that the threshold of awareness among sufferers, doctors, and the general public precludes early identification. (We have always been a nation of battlers, and seeking help is too often left until the severity of symptoms can no longer be ignored, with a majority of people not presenting for assistance until in crisis.) It could, however, also be argued that many people experiencing chronic mild depression or mild anxiety (which has not progressed over time to moderate or severe pathology) do not always need psychological intervention as much as they may need specific life changes and social support such as financial counselling, couples counselling, parenting or housing support, respite care, bereavement care, aboriginal medical services, legal aid or family court advocacy, such as state funded services, community workers and social workers are often best able to address.

Anecdotally, the only early indicator of those clients who will need considerably longer than 10 sessions to experience significant symptom reduction, is chronicity of psychological distress, especially when combined with addictions or a complex trauma history (such as domestic violence and sexual assault). Degree of chronicity of mental disorder is not reflected by the initial K10 score obtained in the GP surgery, and trauma history is seldom obvious from the GP referral information. As previously stated, while 60% – 65% of consumers can be expected to experience initial symptomatic relief within one to seven services, 35% - 40% can be expected to need considerably longer (Howard, Kopte, Krause, & Orliinsky 1986). It cannot however be assumed that these 35% - 40% are necessarily those consumers who initially presented as most severely depressed, anxious (etc), because, paradoxically, "people with severe and debilitating mental illness", have often been found to achieve the fastest initial progress relative to their own baseline (Prytys, 2009). This intriguing finding is a justifiable cause for much optimism regarding the ability of necessarily time-constrained programs such as Better Access to competently service consumers initially presenting with severe levels of distress. (Although it should be noted, that the same relationship does not seem to apply between chronicity of symptoms and rapid early gains in treatment.) This observation is also consistent with that found in the Better Access evaluation:

"Those with comparatively higher pre-treatment K-10 scores (i.e., worse baseline manifestations of psychological distress) demonstrated greater levels of improvement than those with lower pre-treatment scores. For consumers recruited by clinical psychologists, improvements rose at a rate of 0.58 points per each additional one-point increase on the pre-treatment score. For consumers recruited by registered psychologists and GPs, the equivalent figures were 0.81 and 0.53, respectively. In other words, for all three groups of consumers, those with worse baseline manifestations of psychological distress demonstrated greater levels of improvement than those with lower pre-treatment scores. ... One explanation for the pattern we observed may be that those with higher original scores may have greater opportunities to improve before they hit a "floor" score. Another explanation may be that, arguably, they have more "invested" in treatment." Department of Health and Ageing. (2011).

Therefore, the assertion that "individuals requiring more than 10 allied mental health services sessions may be experiencing more severe symptoms and may not necessarily be ideally suited to treatment through a universal Medicare scheme like Better Access" is not consistent with the results of the Better Access evaluation. Generally speaking, individuals with more severe symptoms are being treated successfully within the Better Access initiative, tend to make earlier progress than those with milder symptoms, and do not necessarily choose to consult with a psychiatrist or state public mental health service, even when these services are available.

"87 per cent of current Better Access users receive between one and 10 services and will be unaffected by this change."

National Mental Health Reform - Ministerial Statement.

"Exceptional circumstances" warranting the maximum allowable eighteen services, even for clients with less chronic symptoms and less complex presentations, include adverse life events during the months of therapy, such as experiencing a natural disaster, an unplanned pregnancy, a diagnosis of terminal cancer or a sudden bereavement. Again, the continuity of care able to be provided is pivotal in determining the extent to which people maintain the gains previously achieved and continue to cope with their parenting, work etc roles. Moreover, may I respectfully point out the obvious, - that it cannot simultaneously work both ways – ie. claim considerable savings through this measure yet also claim that few

people will be affected by this change.

*** The assumption that hard to reach and vulnerable groups will somehow be better serviced by these budgetary cuts**

“Savings will be reinvested in other mental health services that target particularly hard to reach and vulnerable groups, who continue to miss out on mental health services, such as the homeless, Indigenous Australians, regional and rural Australia and those Australians with severely disabling mental illness and complex care needs.” National Mental Health Reform - Ministerial Statement.

The reference in the 2011-2012 health budget statement to these identified disenfranchised groups, whose mental health needs have typically been neglected or under-represented within previous mental health policy is heartily applauded. However, “robbing Peter to pay Paul” simply does not make economic sense. The Better Access initiative is the only universal provision for psychological mental health treatment for which Australians from all ages and demographics are potentially eligible, regardless of financial circumstances. The federal government plans to reduce access to up to eight potentially life-saving psychological services for all Australians, including consumers from these identified “hard to reach” groups.

Practice-Based Evidence

For myself and many of my colleagues, each of the above-mentioned demographics have been represented in my practice (including rural farmers and their families who have moved to the Southern Highlands or Shoalhaven following drought, bushfire etc) and I know of no colleagues who have ever been referred that elusively mythical client, - “the worried well”; *“Data collected via our minimum dataset suggest that Better Access consumers are not “the worried well”. The vast majority (over 90%) of our participating consumers had diagnoses of depression and/or anxiety (with or without co-morbid conditions), and many (over 80%) had high or very high levels of psychological distress.”* Department of Health and Ageing (2011).

In my two regionally located private psychology practices I specialize in treating people with complex trauma-related presentations, and so tend to mostly be referred people with “severely disabling mental illness and complex care needs” (including some homeless and Indigenous Australians), initially providing what can be termed “focused psychological strategies” and trauma-informed treatment through the Better Access or ATAPS programs. Like many other senior registered psychologists specialising in treating trauma-related disorders, the most vulnerable GP-referred clients have included many who have been most impacted socially, emotionally and psychologically by multiple, cumulative adverse life events (such as recent family violence and/or adult rape preceded by childhood physical abuse and the suicide of a parent). These consumers, of course, span all social, ethnic and cultural demographics. Those whose earning capacity has been less affected by untreated chronic mental illness have often coped with hidden shame and despair by long-practiced habitual “masking” of depression, suicidal ideation, addictions, substance abuse, eating disorders, panic disorder etc. Given the notorious time constraints of general practice, in combination with the perceived enduring shame and stigma generally experienced, these consumers often continue to disguise the severity of their distress even when requesting psychological treatment (or further treatment) via their GP. Therefore, when first referred to a psychologist, the complexity and chronicity of a client’s care needs may not be immediately obvious from either the GP’s written referral or the patient’s initial presentation.

Other patients are referred with mental health needs which are well documented, but which have never before been addressed from an evidence-based, trauma-informed psychological perspective. As noted earlier, most such consumers, while initially suffering from severe mental illness, are able to make good early gains when provided with trauma-informed psychological treatment, but often cannot sustain these gains over time without extensive further work. This is especially true for clients who also suffer from comorbid disorders such as attachment (relationship) disorders and addictions. For example, chronic or recurrent complex PTSD & Dissociative Disorder treatment outcomes research for chronic childhood victimization indicates a minimum total of 3 - 5 years weekly then fortnightly trauma therapy. Although some psychiatrists have sufficient training or appropriate clinical experience to provide this psychological treatment, most in fact do not, and those who do generally have completely full caseloads or prohibitively long waiting lists. Just as not all psychologists (including both “clinical” and “counselling” psychologists) have had sufficient relevant training and experience to work competently with particular consumer groups such as children or autism, neither, in my opinion, do all psychologists necessarily have the evidence-based training, clinical experience or inclination to work competently with complex trauma presentations, although, of course, many do, - and those psychologists who specialize in treating these complex presentations generally cultivate their skills over decades of experience.

In relative terms, the continuity of care able to be provided throughout a potential maximum of the eighteen services provided through the Better Access initiative has proved potentially life saving for many of these vulnerable consumers. The final 6-8 of eighteen services, though frequently insufficient to build enough resilience to avoid later relapse, do allow sufficient time for further “symptom reduction and stabilization” so that the person may then be able to be referred to other service providers for the remainder of the year. In time, many consumers with some resilience but longer term needs will then “bounce back” for further treatment (often following a re-activation of symptoms). Obviously this is hardly ideal continuity for vulnerable consumers, but, from most consumers’ perspective and in relative terms, they consider this a far better option than the status quo prior to November 2006 when their only options were the fragmented, overloaded and in some cases inappropriately pathologising crisis mental health services available locally to the majority of consumers who lack the priviledged ability to pay for their own treatment. Other

local mental health services appropriate for some consumers include a bereavement care service, limited psychiatric provision or NSW Victims Services. Regarding the latter, while I've received over eighty referrals of families and individuals who followed through to achieve good recovery (using up to 22 hrs specific PTSD etc treatment funded through the NSW Att. Gen. Dep.), this obviously does not cater for all victims of "hidden crimes" who sometimes do not apply for "approved counselling" through fear of repercussions from past perpetrators of domestic violence, or where it cannot be proven forensically that a crime was committed against them (in NSW).

In 30 years of working with highly "at risk" individuals, many of whom initially presented with recurrent major depression, including suicidal ideation, I've been fortunate to have not ever experienced the tragedy of a patient suicide or attempted suicide. This is always a possibility however, and recently I again had to suspend my ATAPS services for any new clients through the local DGP when the maximum number of sessions able to be funded were reduced from twelve to nine, in order for the DGP to ensure that the allocated Commonwealth funds lasted further into the financial year. (Like some colleagues working with consumers with complex care needs, I was for several years providing up to three pro-bono services per person per year, in order to increase continuity when people moved between different programs, but can no longer afford to do so.) Neither could I knowingly ethically accept referrals of these under-serviced and highly "at risk" consumers within the Better Access program if the maximum number of rebatable sessions is reduced to the tokenistic number of 10 services. Furthermore, having just completed a training in Indigenous cultural competence for mental health professionals, with the intention of offering trauma-informed treatment to "stolen generation" clients through the Shoalhaven AMS, if the cuts to Better Access proceed, I will also have to reconsider my decision to offer services for this hard to reach and vulnerable group. If my own stance in not servicing these "at risk" consumer groups within a ten-session program is at all representative of most Better Access psychologists, then expensive crisis hospital care and under-funded state mental health services would again be overburdened with crisis referrals, with grossly insufficient human resources to meet the demand. In the longer term, "saving costs" by reducing universal mental health services does not make genuine savings nor benefit these disadvantaged groups.

*** The belief that those who are affected will be able to access psychiatric services when needed.**

I believe that were this the case, we would not have seen the unexpectedly high take-up of the Better Access option subsequent to the implementation of the initiative. On the South Coast of NSW, even a population centre as large as Nowra has no resident psychiatrist (the closest being Wollongong). There is little public transport from outlying villages in the Shoalhaven area. In the Southern Highlands, there is a 4-5 month waiting list for mental health consumers to consult with one excellent psychiatrist who visits the state funded community health centre.

Furthermore, even in 2011, the perceived stigma associated with the prospect of consulting a psychiatrist (rather than a privately practicing psychologist), has also been a barrier for many who could potentially have benefited through accessing this option, although often seen as providing best for consumers with thought disorders (psychosis/schizophrenia). This is especially the case for an increasing number who are well educated and not open to using psychotropic medications as an adjunct to their therapy, or for who hold respected positions within the community, (such as police officers, navy personnel, teachers, GP's and other health and welfare workers). Writing during the preliminary trials of the Better Access initiative, Professor Stephen Leeder (2006) wrote: *"Beyond concerns with money, the trials also address a health workforce problem. Psychiatrists are a scarce commodity in unrelenting demand. Rural consumers find it difficult to access psychiatric services located primarily in urban areas. Psychologists are more widely dispersed and numerous. There are at least 5000 psychologists in Australia with sufficient clinical expertise to function as mental health specialists and who could provide the style of non-pharmacological interventions that many persons with less severe disorders both need and seek."*

*** The assumption that those who are affected will be able to access other equally appropriate mental health services, including ATAPS.**

Like the Better Access initiative, the ATAPS program also experienced an unexpectedly high take-up of GP referrals to psychologists, and the funds allocated to our local SHDGP have mostly been quite inadequate to enable the program to run the full year, even with the reduction of the maximum number of sessions to 9 (6 plus 3 with a review by the GP following the 6th), and in the last few years, therefore, the local ATAPS program has been restricted to health care card holders only. Ominously, there is no mention in the budget statement of the length of treatment ATAPS will be able to provide.

"It does appear that the ATAPS program will now be required to juggle the disparate needs of several different patient groups, with only a minimal budget increase. If all of the funds provided under this initiative were to go to the provision of ATAPS services, in 2014-15 this would deliver just 310,000 services (assuming the current average cost of \$171 / service continues to apply). At 6 services / patient, this would mean just 51,700 consumers could receive mental health services." Lesley M Russell, PhD (2011)

Interestingly, the Hon Minister for health Dr Nicola Roxan, stated to a live audience on Q&A recently that those who are affected by the cuts to the Better Access initiative will be able to access up to 50 Medicare rebated sessions per year with a psychiatrist or a psychologist, the latter presumably being an unintentional "slip of the tongue". If this were in fact the case, some current Better Access consumers who have contributed their voices to the online petition would not have suffered a recent set-back when learning of the imminent cessation by the Commonwealth of

their ability to continue to access sufficient mental health care of their choice, and I would not have invested time in writing this submission to the Senate Inquiry.

Conclusion

The Better Access initiative has rapidly become an established mental health program, efficiently and effectively meeting what were previously grossly under-served consumer needs within regional mental health care, and with excellent outcome results for consumers proven according to the DoH&A own analysis. Many who experience serious psychological distress associated with mental ill-health and an attendant inability to afford access to “user pays” psychological treatment also lack a political voice. The government claims that few people will be affected by these cuts, yet despite the likelihood that most Better Access patients are probably as yet unaware of these imminent cuts to their ability to access sufficient potentially life-saving treatment of their choice, over 4,000 signatures in an online petition, accompanied by the written pleas of literally thousands of consumer “voices”, testify silently but compellingly that the claim that few people will be affected is manifestly untrue (See Appendix). As others writing about priorities for reform within primary health have asserted, given the focused attention upon promised additional mental health spending in the 2011-2012 health budget, more than ever before “we need the powerful voice of the people, not the voice of powerful people” to inform mental health funding priorities.

In my opinion, only when mental health policy is informed less by “noisy” vested interest groups and more by the voices of consumers, combined with sound evidence based upon both independent outcomes research and practice based evidence, shall all Australians have “Better Access” to affordable mental health services when and where they are most needed. I am optimistic that the Senate Inquiry will not only question the rationale behind the proposed Better Access budgetary cuts but also apply foundational principles of universality, equity and efficiency in reviewing the status quo of the Better Access initiative and associated issues within mental health policy. Please reconsider this regressive budgetary measure.

A sample of petitioner’s comments have been included as an Appendix. This petition states:

“We call on the Federal Minister for Mental Health to re-instate a fair policy for mental health care, namely 12-18 sessions with a psychologist, social worker, occupational therapist, or GP specialising in mental health care in the 'Better Access to Mental Health Care' initiative.”

The full petition can be read online at: <http://www.gopetition.com/petitions/better-access-to-psychologists.html>

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