

## **Western Psychological Services**

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Committee Secretary  
Senate Standing Committees on Community Affairs  
PO Box 6100  
Parliament House  
Canberra ACT 2600  
Australia

Dear Committee Members,

The investment in new and expanded programs announced in the Budget is welcomed and valued. However, proposed cuts to the maximum number of Medicare rebated consultations per annum from 12 to 10, and cessation of the "special circumstances" provision, effectively reducing the number of sessions from 18 to 10, will on the balance of probabilities likely introduce unintended inequality and reduction in access to provision of specialised mental health care services and increase disadvantage to people with moderate to severe mental illness in the middle and outer Western suburban areas of Melbourne serviced by our Psychological Practice, and other areas of disadvantage.

### **Summary**

First, it will be argued that the 18 maximum permissible consultations under the Better Access system be retained and preferably increased for people in disadvantaged populations including those identified as; aboriginal, having serious mental ill health disorder (SMHD), culturally and linguistically diverse communities (CALD), and disabilities. Second, it is reasoned that the "Better Access" referral pathway often

enables equitable and efficient access for disadvantaged people. Although “Access to Allied Psychological Services” (ATAPS), consultant psychiatrist services and public mental health systems in each State or Territory are compatible with the services provided by Psychologists through “Better Access”, the latter is an important partner of these services and meets needs that are either difficult or not possible to meet in these other systems.

Third, it is argued that the Clinical Psychology item codes and rebate be retained to maintain access and to reduce disadvantage to under privileged clients.

Fourth, it is argued that additional Specialist Psychology specialisations in mental health (e.g. counselling; educational and developmental; health; clinical neuropsychology) be given their own specialist item codes to acknowledge their nationally recognised specialisations.

These points are expanded in relation to their terms of reference below in relation to:

*1. “The impact of changes to the number of allied mental health treatment services”*

Up to 12 sessions of treatment with a psychologist per calendar year can be currently accessed. The referring medical practitioner may consider that in “exceptional circumstances” the person requires an additional six sessions of psychological treatment (to a maximum total of 18 individual services per person per calendar year).

The Government has stated that the cuts to Better Access equate to 13% of people treated by psychologists who are seen for more than 10 sessions. In the first 3 years of the Better Access initiative (2007–2009 11) over two million individuals received services from psychologists under Better Access and 262,144 (13%) of these people received more than 10 sessions of psychological treatment.

In our service, based in the middle to outer west of Melbourne, “Better Access” services are largely utilised by people with moderate to serious mental health disorders and not the “worried well”, as sometimes portrayed in the media. In a population of 790 Better Access clients since inception of the program, over 85% presented with a diagnosis of an anxiety or depressive disorder, 8% as having a diagnosed psychosis or bipolar disorder, and 85% were assessed as experiencing high or very high psychological distress as indicated on the self-report measure, the K10. Importantly, those with the most severe pre-treatment distress scores experienced the greatest symptom improvement scores. These results are consistent with a study by Pirkis (et. al., 2011). In addition, over half had rather complex presentations with either an additional mental health disorder, or personality disorder or significant chronic medical condition. Importantly, 15% of clients received more than 12 sessions, and of these, 95% rated their initial distress as high or very high, and nearly half reduced their symptom presentation to either a non-clinical or mild symptom result. The results demonstrate for our service that Better Access is effective for people with significant mental health conditions and that proposed changes to reduce the number of sessions will cause great disadvantage to our already socially, psychologically and economically vulnerable client group.

It seems that the data reflect some consistency in the severity of psychological distress between Melton, a socially disadvantaged and rapidly growing suburb of low

income status and relatively poor health outcomes, and the national data. In particular, Better Access seems to be reaching those who, in the main, are in need and in significant psychological distress rather than those who do not need it.

Notably, the Better Access scheme has greatly increased access to services across all sections of the population in Melton and surrounding areas, but particularly for those who are socio-economically disadvantaged. Our practice bulk bills or provides a reduced fee for those people on a pension or health care card. These clients were not able to access our service prior to "Better Access", when the bulk of our clientele over a 15 year period were workers from middle income families.

In particular client treatment outcomes were similar to those reported in the Medicare evaluation (Pirkis, et. al., 2011) and indicate that a socio-economically disadvantaged area such as Melton has benefitted from Better Access as has the wider community.

Any cut to the present maximum of 18 permissible annual Medicare subsidised consultations directly undermines the mental health treatment of people who have significant depression, anxiety disorder(s) or other mental ill health disorders. The reduction from potential 18 to 10 sessions with a psychologist, particularly for those who have a severe mental ill health condition and related disadvantaged groups (e.g. CALD, aboriginals, disabled, LBGT) will disadvantage those who most require it, and will dramatically impact on people with severe mental health problems, who will be denied access to a relatively fair and equitable, and effective treatment program through "Better Access."

I strongly and respectfully urge the Senate committee to facilitate the continuation of the present maximum allowable sessions of 18 maximum permissible consultations under the Better Access system and review this maximum particularly for disadvantaged populations including those with a serious mental health disorder (SMHD), culturally and linguistically diverse communities (CALD), aboriginal people, and people with disabilities.

*2. "The impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program;"*

It is reasoned that the "Better Access" referral pathway often enables equitable access to disadvantaged people and that although "Access to Allied Psychological Services" works well, has inherent problems ameliorated by the "Better Access" referral pathways. In addition, consultant psychiatrist services and public mental health systems in each State or Territory have their strengths and weaknesses. "Better Access" currently is an important partner of these services and meets needs that are either difficult or not possible to meet in these other systems.

The proposed alternatives are unlikely to adequately meet the needs of people with serious mental health disorders who need more than 10 sessions of treatment. The government has advised that they should receive services through the specialised public mental health system or private psychiatrists. Our psychological service has

access to ATAPS funding also, and whilst this is an important adjunct to our work, as is that of private psychiatrists and public mental health facilities whom our clients interact with, several problems seem to arise:

The Federal Budget papers states:

*"The new arrangements will ensure that the Better Access initiative is more efficient and better targeted by limiting the number of services that patients with mild or moderate mental illness can receive, while patients with advanced mental illness are provided with more appropriate treatment through programs such as the Government's Access to Allied Psychological Services program."*

Our service's experience with ATAPS is variable and largely dependent on the administrators of the scheme. We have had access to funding from two divisions of general practice over the past 5 years. Current ATAPS funding models are inconsistent, their efficiency is dependent on who is managing the dissemination of funds, they are not equitable as some providers are favoured over others, staff changes in some areas effect continuity and this uncertainty impacts on referrals from participating GP's, funding has at times ceased suddenly during the course of treatment with clients, and funding is very limited in terms of actual ability to service clients. In addition, ATAPS providers do not have the more rigorous requirements required of those providing services under Better Access. For example, some GP Divisions have employed people who are yet to be registered as psychologists. The above problems have not been experienced under the Better Access model.

The typical cost of a package of care delivered by a psychologist under the initiative is about \$750, significantly less than ATAPS which costs between two to 10 times that of Better Access service provision per session (source; Australian Psychological Society, 2011).

The Department of Health and Ageing Fact Sheet on the Budget measure states:

*"People with severe and persistent mental disorders who require over 10 allied mental health services are still eligible for up to 50 Medicare Benefits Schedule consultant psychiatrist services per annum, or to access the specialised mental health system in each State or Territory."*

There are limited private psychiatric services to refer people to with no psychiatrist servicing a population of over 100,000 in Melton, and general shortages nationally. One psychiatrist per 10,000 populations is recommended. Also, there is a clear focus on assessment and the bio-medical approach, and not specialist psychological counselling. The evidence is clear that effective treatments for serious mental health problems may incorporate both medical and psychological approaches. Specialised psychological intervention is imperative for the person with a severe mental health condition.

3) Public Mental health for adults particularly caters for those at serious risk of suicide and for people in their acute phase of mental illness. They are not, and have never been a facility that provides psychological therapy, indicating there is a significant and poor understanding of the differentiation between psychologist's roles in Better Access and Public Mental Health services. Indeed, public mental health services do not conduct psychological therapy with commonly occurring mental health problems such

as mood and anxiety disorders designed to be treated by the “Better Access” system. Moreover, most clients at our practice when asked anecdotally did not want to access team-based nor public psychiatric services unless in a deleterious clinically acute phase of their condition.

*(3) “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”*

Our practice offers bulk billing services for disadvantaged groups. If the Medicare rebate for clinical psychologists were reduced, this would result in the discontinuation of the Bulk Billing arrangement at Western Psychological Services. Clients would no longer be able to access bulk billing services at the lowest rebate fee due to the costs of running the practice with eight psychologists who include counselling, general, clinical and educational and developmental psychologists. This would have significant negative consequences for client access to mental health services, and for risk management as many pose a risk to themselves or others. Subsequently, psychological treatment would only be available to those with higher levels of income and as such would be highly discriminatory, particularly as many clients with serious mental illness have significant difficulties in obtaining and sustaining employment.

Like my clinical psychology colleagues in Melton who bulk bill, I urge the Senate committee to consider, at a minimum, retaining the current clinical psychology item codes and clinical psychology rebate to continue access for the most socio-economically disadvantaged members in our community.

*(4) the two-tiered Medicare rebate system for psychologists, workforce qualifications and training of psychologists*

It is argued that additional Specialist Psychology specialisations (e.g. counselling; educational and developmental; health; clinical neuropsychology) be obtain their recognised with their own specialist item codes to acknowledge their national and internationally recognised specialisations.

Clinical Psychology is one of nine specialisations within Psychology and all are recognised within Australian legislation, and form the basis of industrial awards. All specialisations require eight years training including a further ACPAC accredited postgraduate training in the specialisation leading to an advanced psychological competency in that field. These are recognised as specialised areas of endorsement and in addition, are internationally recognised.

I am of the opinion, as are some of my colleagues, that each area of specialisation relevant to providing specialist mental health services requires a specialist rebate with its own item number relating to the specialist domain of that area of psychology, including Clinical Psychology. Incorporating other specialisations of psychology could assist in the provision of providing specialised areas of contribution to the mental health landscape, as do psychologists who are currently able to treat pervasive developmental disorders within Better Access. This may lead to common areas of

treatment, and areas of treatment pertaining to that specialisation (e.g. Clinical Neuropsychology; assessment and treatment of cognitive impairment); members of the psychology profession may want to undertake further training to attain those other advanced specialised competencies that are not part of their training.

Thank you for the opportunity to discuss the above concerns and recommendations on behalf of our community of disadvantaged clients.

## References

Pirkis J, Harris M, Hall W, Ftanou M. (2011). *Evaluation of the better access to psychiatrists, psychologists and general practitioners through the medicare benefits schedule initiative: summative evaluation*. Melbourne: Centre for Health Policy, Programs and Economics, University of Melbourne.

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