The Australian Psychological Society Ltd

Submission to the Senate Standing Committee on Community Affairs

Reference: Mental health services in Australia

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1. Better Access uptake statistics and costs

The Better Access initiative has been rolled out on a national scale with relatively few implementation problems, which is a credit to the Australian Government, the professional associations involved and individual service providers. The huge uptake statistics for the allied mental health items are indicative of a previously unmet community need for psychological treatment, and the inclusion of these services under Medicare is thus anticipated to have a substantial impact on the mental health of the community.

By far the vast majority of individual Medicare services under the Better Access initiative have been provided by psychologists. Medicare Australia statistics for the period from the introduction of the initiative in November 2006 to the end of March 2008 indicate a total of 1,898,526 individual psychology service items were provided by psychologists, made up of 1,265,265 general psychology items and 633,261 clinical psychology items. During this same period, a total of 67,355 individual services were provided by social workers and 12,375 were provided by occupational therapists. For the same period, there were 655,996 items for the preparation of GP Mental Health Care Plans (the process by which GPs plan treatment and refer clients to eligible allied health Medicare providers) and 152,115 GP review items.

The demand for services from psychologists grew exponentially over the first ten months of the initiative and since then there has not been a diminution in demand. The uptake has far exceeded Government expectations and demonstrates the clear and unabating community demand for accessible treatment services delivered by psychologists.

Medicare Australia costs for the Better Access initiative to the end of December 2007 show that a total of $279 million dollars has been spent on the initiative. Table 1 shows the breakdown of costs, with $121 million dollars being spent on GP items, $21 million dollars on psychiatrist items and $136 million dollars on allied health professional items. These figures illustrate the cost associated with services from GPs for the purposes of referral and review is comparable to the total cost of treatment provided by allied health professionals.

Table 1. Medicare Australia data for costs of the Better Access initiative – November 2006 to end of December 2007

Health Professional items	Cost accrued	%
GPs (Mental Health Care Plans, reviews and consultations)	$121,000,000	43%
Psychiatrists (consultation and referral)	$21,000,000	8%
Allied health providers (treatment)	$136,000,000	49%
Total	**$279,000.000**	**100%**

2. APS survey data on the Better Access initiative

The APS has conducted two surveys of psychologists registered with Medicare regarding their use of the Better Access Medicare items, the most recent being the largest survey which is reported on below. The APS is also in the process of collecting consumer feedback on the effectiveness of the psychological interventions they have received and the impact of the MBS rebate on their capacity to access psychological services. The consumer survey will not be completed until mid-June, however we have been able to include some preliminary results in this submission. The APS also collects data on the Better Access initiative through its Department of Health and Ageing-funded role as the Allied Mental Health Consultant, which provides a telephone and email advisory service to allied mental health providers, Divisions of General Practice, referring GPs and psychiatrists.

2.1 APS Better Access psychology provider survey

In the most recent and largest survey of psychologists providing services under the Better Access initiative, over 4,000 psychologists received the survey and 2,106 psychologists responded. Of the psychologists who responded, 649 identified themselves as registered with Medicare as a clinical psychologist and 1,036 were general psychologists registered with Medicare under Better Access. The remaining 421 participants did not specify the type of services they provide under Medicare. The results of the survey are detailed below.

Provision of services in rural locations

Twenty-four per cent of general psychology providers were providing services in rural and regional locations, while 16 per cent of clinical psychology providers were located in these areas.

Client access to services

Surveyed psychologists reported that 72 per cent of clients that were referred under the Better Access initiative had never seen a psychologist before. Psychologists reported that they believed 73 per cent of their Better Access initiative clients could not have accessed psychological services without the Medicare rebate being available. Eighty-one per cent of the clients referred under the Better Access initiative were new to the psychologists' practices.

Client demographics

The demographics of the clients of psychologists surveyed were 62 per cent female and 38 per cent male. Ten per cent of clients were aged 12 years or under, 26 per cent were 13-25 years old, 57 per cent were 26-65 years old, and seven per cent were over 65 years of age.

Prevalence of mental health disorders

Psychologists reported treating clients with a range of mental health disorders under the initiative. The most frequent presentations were depression and/or anxiety (48%), with a

range of other disorders occurring at lower rates. The most commonly reported presentations are provided in Table 2.

Table 2. Most common mental health disorders treated by psychologists under Better Access

Diagnosis	**Percentage of clients**
Depression	18%
Co-occurring anxiety and depression	17%
Anxiety	13%
Post-traumatic stress disorder	6%
Adjustment disorder	6%
Psychosis, schizophrenia, bipolar disorder	6%
Drug and alcohol use disorder	6%
Other diagnostic categories	28%

Severity of mental health disorders

Psychologists completing the survey reported that most clients seen presented with disorders in the moderate (46%) or severe range (35%). A smaller group (19%) of clients were described as experiencing a mild level of difficulty. These figures indicate that the vast majority of clients seen under Better Access are in significant need of treatment services.

Number of sessions required for completion of treatment

Table 3 presents the number of sessions that clients required for completion of psychological treatment. Surveyed psychologists reported that the majority of clients (69%) required between 5 and 12 sessions for completion of treatment. However, a significant number of clients (15%) were found to require more than 12 sessions.

Table 3. Number of sessions required for completion of psychological treatment under Better Access

Number of sessions required for completion of treatment	**Percentage of clients**
One session only	4%
2 - 4 sessions	12%
5 - 6 sessions	22%
7 - 9 sessions	15%
10 - 12 sessions	32%
13 - 17 sessions	6%
18 sessions	9%

Fees and bulk billing rates

The average fee (for a greater than 50 minute session) charged for a Better Access service reported by the large sample of psychologists who completed the survey was $102 for a general psychology provider and $131 for a clinical psychology provider. These figures demonstrate that psychologists are charging Better Access clients fees that are relatively close to the schedule fee set by Medicare ($90.15 for a general psychology provider and $132.25 for a clinical psychology provider).

General psychology providers completing the survey reported bulk billing approximately 50 per cent of their clients while clinical psychology providers reported bulk billing approximately 47 per cent of their clients. The most common reasons for determining whether to bulk bill a client were the client having a healthcare or concession card, financial disadvantage, or on GP recommendation.

Process of referral from GPs to psychologists

Psychologists surveyed reported that 27 per cent of GP Mental Health Care Plans (the process of mental health assessment and referral to psychologists) do not reflect an accurate diagnosis. Thirty-three per cent of psychologists surveyed believed the GP's Mental Health Care Plan did not capture the most important features of a client's diagnosis and contributing issues. The survey indicated that psychologists need to subsequently conduct their own full diagnostic assessment of 86 per cent of their Better Access clients.

Psychologists also reported that 15 per cent of GPs do not activate the appropriate Medicare item number for the Mental Health Care Plan, which results in clients being unable to claim Medicare rebates. Twenty-four per cent of GPs reportedly do not send the Mental Health Care Plan with the referral to the psychologist, which can create difficulties in the initial session with a client.

2.2 APS Better Access client survey

Preliminary data is available from the survey of clients who have completed treatment from a psychologist under the Better Access initiative. Better Access clients are invited to complete the simple and anonymous survey at the end of their treatment with a psychologist and are able to send it postage-paid to the APS. To date 1,074 client surveys have been received. The results of the survey are detailed below.

Client demographics

Of the clients who have responded to the survey, 65 per cent are female and 35 per cent are male. The average age is 41 years, with an age range of 8 to 80 years.

Affordability of treatment

Ninety-six per cent of Better Access clients reported that they would not be able to afford to receive treatment from a psychologist without the Medicare rebate.

Treatment effectiveness

Clients were asked to indicate the level of improvement they have experienced as a result of the psychological treatment on a five-point scale of 'no improvement' to 'very significant improvement'. Ninety-one per cent of clients indicated that treatment had resulted in significant (47%) or very significant (44%) improvement, indicating the perceived effectiveness of the psychological treatment. Eight per cent of clients indicated moderate improvement resulting from treatment, while only 0.7 per cent indicated that there had been little improvement and 0.2 per cent indicated no improvement.

Number of sessions required for completion of treatment

The average number of treatment sessions received by surveyed clients who had completed treatment was nine. Thirty-eight per cent of clients received 1-6 sessions, 47 per cent reported receiving 7-12 sessions and 15 per cent received 13-18 sessions.

3. Responses to voiced concerns regarding the Better Access initiative

There has been frequent criticism in the media from prominent and vocal opponents of the Better Access initiative that the high costs associated with the greater than expected uptake of psychological treatment services could be better spent on other mental health initiatives. The huge community demand for psychological services under the initiative has obvious implications for the costs of the initiative, but demonstrates the need for such services and the community acceptance of this system of referral and treatment.

It is concerning, however, that from a total of $279 million dollars spent on the Better Access initiative by the end of December 2007, 43 per cent of these funds were expended on GP consultations, and in particular on the preparation of GP Mental Health Care Plans and GP review items ($121 million). This is compared to the total cost of treatment provided by allied health professionals of $136 million. These figures represent an imbalance of expenditure on the development of Mental Health Care Plans compared to provision of treatment, which is difficult to justify and requires some adjustment.

The data from the APS surveys of over 2,000 psychology Medicare providers and over 1,000 Better Access clients provide information to counter the specific concerns that have been raised by critics of the Better Access initiative. The criticisms of the initiative that have been frequently reported in the media centre around three main issues:

- That the initiative is providing services to the 'worried well' at the expense of people with significant mental health problems;

- That the rate of bulk billing for services delivered under the initiative by psychologists is very low and psychologists are charging high fees for services, resulting in prohibitive gap payments for the financially disadvantaged; and
- That psychological services are not being equitably provided to people in rural and regional areas under the initiative.

These concerns are addressed below with reference to APS survey data, and, where appropriate, recommendations are provided in response to each issue.

3.1 Better Access client profile

The APS survey data indicate that 48 per cent of clients seen under Better Access have the diagnosis of depression and/or anxiety, the high prevalence disorders that the initiative was designed to address. The survey figures reflect the prevalence of these disorders in the community. Similarly, the survey data show that six per cent of clients seen under Better Access had the diagnosis of psychosis, schizophrenia or bipolar disorder, which is consistent with community prevalence. The survey data indicate that 81 per cent of Better Access clients are classified as having moderate or severe mental health problems. These figures confirm that clients who are referred to psychologists under Better Access are in significant need of psychological treatment.

Data show that 72 per cent of clients have never consulted a psychologist before. Ninety-six per cent of Better Access clients surveyed reported that they would not have been able to afford to seek psychological treatment without the Medicare rebate. These clients are now able to access effective and early treatment from psychologists, which is likely to be having a substantial impact on the mental health of the community. The universal availability of psychological treatment through the nation's funded health system has possibly also contributed to a destigmatisation of help-seeking for mental health problems, which is an important development.

3.2 Access for those most in need

The average fee charged for a Better Access service (50+ mins) by psychologists who completed the APS survey was $102 for a general psychology provider and $131 for a clinical psychology provider. These figures demonstrate that surveyed psychologists are charging Better Access clients fees that are relatively close to the schedule fee set by Medicare ($90.15 for a general psychology provider and $132.25 for a clinical psychology provider).

The APS survey indicates that the average gap payments, calculated as the average fee charged less the Medicare rebate, are $25.35 for general psychology providers and $18.55 for clinical psychology providers. Medicare Australia data was released in April 2008 and

indicated the average gap payment was $33.41 for services from general psychologists and $27.97 for clinical psychology services. Comparisons have been made in the media between the gap payments for services from psychologists and those provided by GPs and psychiatrists under the Better Access initiative. These comparisons are not equitable as the schedule fees and rebates for services provided by GPs and psychiatrists are so much higher than those for psychologists. For example, the schedule fee for GPs to deliver Focused Psychological Strategies (FPS) is $117.55 and this attracts a 100 per cent rebate. General psychologists delivering exactly the same FPS services (although arguably as more experienced clinicians, as GPs are only required to undergo 26 hours of training to be eligible) have a schedule fee of $90.15 with a rebate set at 85 per cent ($76.65).
General psychology providers completing the APS survey reported bulk billing approximately 50 per cent of clients, while clinical psychology providers reported bulk billing approximately 47 per cent of their clients. The April 2008 Medicare Australia data on bulk billing rates indicated that general psychologists had a rate of 30.4 per cent, while clinical psychologists bulk billed at a rate of 25.9 per cent. The discrepancy between the Medicare Australia data and that from the APS survey is most likely explained by differences in calculation methods based on numbers of clients compared with numbers of consultations. Again, the comparisons with bulk billing rates for GPs and psychiatrists are not equitable as payment rates differ so markedly. In the example of GPs delivering FPS services outlined above, a GP would receive $40.90 more than a psychologist if they bulk billed for the same service, which clearly provides greater incentive to bulk bill.

The most common reasons surveyed psychologists gave for determining whether to bulk bill a client is where they have a healthcare or concession card, are experiencing financial disadvantage, or on GP recommendation. Although many psychologists bulk bill consumers who are financially disadvantaged, it is recognised that, given the current rebate levels, it is not financially viable to run a practice that operates primarily through bulk billing, especially for general psychologists.

There are a number of ways to increase the rate of bulk billing among psychologists that the Government could consider to increase the accessibility of services to low income consumers. These include the provision of online bulk billing payment from Medicare, increasing the rebate to 100 per cent of the schedule fee (as for GPs), providing financial incentives for bulk billing, and increasing the schedule fee for the psychological services items. These methods have all been successfully used by the Government to increase the rate of GP bulk billing for medical services and should be considered for psychologists.

3.3 Rural community access to Better Access services

The APS survey found that 16 per cent of clinical psychology providers and 24 per cent of general psychology providers reported that they were located in regional/rural areas.

Medicare data suggests that approximately 25 per cent of Better Access psychology consultations occur in rural areas.

The APS has mapped its membership across Australia to demonstrate the broad coverage that psychologists currently achieve. While the distribution of psychologists is far better than psychiatrists, there will always be a need to look at ways to attract new clinicians to these areas and retain the existing professionals in these settings. In conjunction with all the Psychologists Registration Boards, the APS is currently conducting a comprehensive workforce survey of psychologists across the whole of Australia. This survey will assist in accurately planning for services under the Better Access initiative by providing more accurate data than is currently available (AIHW data is quite flawed).
The inequity in the provision of mental health services in rural Australia is a significant challenge that can only be addressed through increasing the rural psychology workforce and capacity. There are a number of strategies using financial incentives that the Government has implemented to attract and retain medical practitioners in rural locations, and these should be considered to expand the rural psychology workforce. Other possible measures include engagement of psychologists through entities such as the proposed GP superclinics to deliver Medicare-funded services, an increase in financially supported clinical training placements in regional/rural areas, an increase in psychology places and scholarships at universities offering flexible distance education, and an expansion of the psychology Medicare items to include tele-psychology and videoconference services.

4. Identified Better Access service provision issues

4.1 Duplication of costs associated with client assessment

In the APS survey of psychology providers, psychologists reported that 27 per cent of GP Mental Health Care Plans do not reflect an accurate diagnosis and that they subsequently need to conduct their own full diagnostic assessment of 86 per cent of their Better Access clients. Although it is recognised that a large proportion of GPs accurately identify patients who are appropriate for the development of Mental Health Care Plans, many GPs have not had sufficient training in the diagnosis of mental health disorders (particularly co-morbidity, which is relatively common) and the construction of the most effective and efficient treatment plans. Feedback from telephone calls from psychological practitioners in the field and the APS survey data indicate the questionable quality and value of some GP Mental Health Care Plans.

Better Access costs could be dramatically cut by reducing the role of the GPs in the assessment process and the requirement for them to write a Mental Health Care Plan. It is still suggested that GPs remain at the centre of patient care, and the ‘gatekeepers’ to treatment, by establishing that the patient has a mental health problem as part of a regular consultation and then referring the patient to a psychologist for a comprehensive

assessment, diagnosis and treatment plan. This would reduce the administrative burden for GPs by removing the need to complete a Mental Health Care Plan, address the duplication that is currently occurring when psychologists have to undertake another assessment, and also improve the client's treatment outcomes through more accurate diagnosis and streamlined treatment.

4.2 Quality and effectiveness of treatment

The APS client survey indicated that 91 per cent of clients who had received treatment from a psychologist under Better Access indicated that the treatment had resulted in significant or very significant improvement. Psychologists are trained to deliver evidence-based treatments and it is essential that high quality services are maintained to ensure the continued effectiveness of treatments delivered under Better Access. The current push for counsellors to be included in the Better Access scheme is of grave concern. Counsellors are often minimally trained with few skills in the assessment and treatment of mental health disorders, are not required to be registered to practice with a statutory authority, are not subject to disciplinary codes, and frequently do not engage in evidence-based treatment practices.

To ensure the quality and effectiveness of treatment provided by allied health providers under Better Access, the APS recommends that a rigorous and mandatory Continuing Professional Development (CPD) program should be instituted for all allied health providers delivering Focused Psychological Strategies items. Clinical psychology providers are already required to engage in CPD to maintain eligibility to provide specialist items under the Better Access initiative. A CPD program for all treatment providers will assist with the delivery of high quality cognitive behaviour therapeutic techniques and help to ensure that Medicare funds are expended on evidence-based treatments. The APS, along with the Council of Psychologists Registration Boards, is currently developing and piloting a national system of CPD so that there is only one system which monitors appropriate CPD standards for psychologists across Australia in preparation for the national registration and accreditation scheme for health professionals. This system should be used for Medicare-registered psychologists to ensure a compatible set of requirements.

An additional issue in relation to the quality of services provided under the initiative is that there needs to be financial recompense for psychologists to engage in multidisciplinary case conferences for clients seen under Better Access. Clients with complex needs require multi-disciplinary approaches and consultation between professions is often needed. Team-based work across the mental health professions is important for more effective and efficient services and better client outcomes. Currently there are Medicare items for the medical profession to engage in case conferencing for clients with complex needs and these should be extended to include psychologists.

4.3 Provision of services to the parents of children with mental health problems

Under the current requirements of service under the Better Access initiative it is not possible to charge for sessions with a parent of a child who has been referred for treatment unless the child is present. Provision of psychological services to the parents of a child who has been referred is an essential and often the most effective component of the treatment of the child. Unless the 'identified patient' (i.e., the child) is present, services provided to a parent or carer are not allowable under the Better Access initiative. This issue could be addressed by including appropriate wording in the MBS notes to allow for parents and significant others to be included under these Items in relation to the treatment of young children.

II. Other matters

1. Impact of Medicare on public mental health psychology services

The introduction of Medicare-funded psychology services has increased the attractiveness and viability of private practice for psychologists, which carries implications for recruitment and retention of psychologists within the public mental health sector. This is exacerbating the existing shortage of clinical psychologists in the public sector and potentially diminishing the quality of care available to patients in public mental health settings.

1.1 Survey of Melbourne public sector psychology workforce

A special forum was held last year for a group of senior psychologists in public health settings across metropolitan Melbourne (the Heads of Psychology Group), which focused on the impact of the introduction of Medicare rebates on psychology services within public mental health. The meeting generated a high degree of interest and discussion beyond the forum, and provided the impetus to conduct a survey of the future employment intentions of public mental health psychologists in the context of the availability of Medicare rebates.

The anonymous survey was completed by 98 psychologists at all levels within public sector mental health services. The survey gathered information on the psychologists' employment intentions over the next one and two years, their plans and active preparation to commence or increase private practice, their motivation to leave the public sector or reduce hours in favour of private practice, and factors that would lead to a reconsideration of plans to leave or reduce hours of work in the public sector.

The results of this survey indicate that the majority of psychologists employed in public mental health services are committed to remaining actively involved within public sector mental health services for a significant period of time into the future. However, a third of psychologists surveyed indicated that they intended to reduce their working hours for private practice over the next two years. Of significance, 41 per cent of more senior P3-level psychologists indicated an intention to reduce their hours over the next year to take up or increase private practice activities, and a significant proportion are already actively making these preparations.

Of those psychologists who indicated that they were preparing to leave the public sector, reasons for preparation to leave were relatively evenly distributed over increased opportunities and remuneration, greater flexibility, and autonomy. Improvements to current employment conditions that psychologists reported may lead them to reconsider their private practice plans included improved remuneration (40%), increased specialist psychology work (27%), promotion opportunities (26%), increased study/conference leave (22%), additional annual leave (22%), improved professional development opportunities (21%), increases in provision of private practice rights (19%), and research opportunities (14%).

Although most surveyed psychologists are committed to remaining in the public mental health services, it is of concern that a significant proportion of senior psychologists are contemplating reducing their hours of work for private practice. The survey data suggest that there is a raft of factors that will shift the intentions of psychologists to leave public sector employment and these should be vigorously pursued by policy makers in government health departments and health services.

1.2 Recruitment and retention of psychologists within the public sector

Funding for private psychology services in the community should not be provided at the expense of public mental health services; both systems are needed to be working in a complementary manner to address the continuum of mental health needs of the Australian community. Australia must maintain high quality inpatient and outpatient public mental health services that offer psychological expertise, particularly in the assessment and treatment of people with the most severe, complex and enduring mental health disorders.

Measures to increase the incentives for psychologists to work in the public sector are thus essential and include increased opportunities for specialist psychological work, provision of private practice rights within employment akin to those available to the medical profession, improved career structures and increased remuneration. The Melbourne forum explored opportunities and models for public/private partnerships which would be suitable for a particular target client group. These services could be for clients with 'sub-threshold' presentations that are not likely to meet formal inclusion criteria for treatment in the public system, or clients on discharge from the service. It is evident that new models for working will begin to emerge as the result of workforce planning within this new climate.

There are some pleasing recent developments in the Victorian public mental health sector, with a new industrial agreement in April this year, between the Department of Human Services and the health services, containing significant measures to attract and retain clinical psychologists. These include salary increases, agreement on further negotiations for an enhanced career path, and further negotiations for the development of a model of private practice rights. These measures are likely to reduce the potential drain of experienced clinical psychologists into private practice. The ultimate beneficiaries of this will be the clients of the public mental health services, who need access to clinical psychology services and whose needs cannot be met under the private Medicare system. It is hoped that other State jurisdictions will follow Victorian developments on this issue.

2. Mental health Postgraduate Scholarship Scheme for clinical psychology

The Mental Health Postgraduate Scholarship Scheme (MHPSS): Clinical Psychology is a five-year initiative funded by the Australian Government as part of the COAG mental health reforms, which introduced 200 new HECS-funded clinical psychology places across the university system to address the shortage of qualified mental health professionals. The aim of the MHPSS is to encourage and support individuals interested in undertaking a Masters degree in clinical psychology.

The APS administers the scheme to advise on appropriate criteria and guidelines for the selection of students to be awarded funding under the scheme, and also manages the selection process. The selection process for 2007 resulted in the awarding of 48 scholarships. Fourteen of the applicants were identified as living or having lived in a rural or remote area and one of the applicants was identified as being of Aboriginal or Torres Strait Islander background.

The selection of MHPSS scholarship recipients for 2008 was limited to students in three specific categories – those from culturally and linguistically diverse (CALD) backgrounds, Aboriginal and Torres Strait Islander (ATSI) heritage, and residents from rural and remote Australia (RRA) – or to students who could demonstrate a commitment to working with these populations or in these locations. The selection process for 2008 resulted in the awarding of 44 scholarships to study clinical psychology – 10 for CALD students, three for ATSI students and 31 for RRA students.

3. Indigenous workforce and service delivery

Psychological knowledge and practice has much to offer to address the disadvantage and associated high levels of mental health problems experienced by Australia's first peoples, who represent 2.4 per cent of the Australian population. More Indigenous psychologists are needed to contribute their unique understanding in areas of mental health policy, research and professional practice. There are currently about 30 Indigenous psychologists in Australia, and, if the numbers were proportional to the number of practising psychologists in the Australian population, there should be around 500 Indigenous psychologists.

The APS aims to increase the representation of Indigenous psychologists in the profession and this was one of the motives for the establishment of the APS Bendi Lango Foundation which funds scholarships to support Indigenous postgraduate psychology students. A new organisation for Indigenous psychologists – the Australian Indigenous Psychologists Association (AIPA) – is currently being established within the structure of the APS.

The first ever meeting of Indigenous psychologists in Australia was held in Melbourne in March this year. The group provided a valuable review of current practice and service

arrangements for Indigenous clients seen under the Better Access initiative and raised the following issues:

- The need for a referral from a GP to access treatment from a psychologist should be removed to allow referral from other professionals, self-referral and referrals from third parties (e.g., relatives).
- Longer time should be allocated to assess an Indigenous person and more valid forms of assessment are required as many assessment tools are culturally inappropriate.
- Indigenous clients need longer appointment times and will usually need more than 12 sessions.
- All Indigenous clients should be bulk billed and the bulk billing rebate for Indigenous clients should be increased
- All psychologists should have Indigenous cultural competence as part of a requirement of registration, as is the case in New Zealand and the USA. Cultural competence should therefore be included in university training programs and ongoing professional development.

4. Concerns regarding the Better Outcomes in Mental Health Care program

The Better Outcomes in Mental Health Care program, which was introduced by the Australian Government in 2001, laid the foundations for the Better Access to Mental Health Care initiative and remains operational. The Better Outcomes program is implemented through the Australia-wide network of Divisions of General Practice (DGPs) which receive funding to purchase psychological treatment services under the Access to Allied Psychological Services (ATAPS) arm of the program.

The APS strongly supports the Federal Government's continued funding of the Better Outcomes program, although there are a number of concerns with aspects of its operation. The Better Outcomes program appears particularly well suited to deliver services where targeted populations need special attention, as it is easier to administer targeted programs through DGPs. Thus, rural and remote mental health treatment services are administered effectively through Better Outcomes due to the locations of particular DGPs. The APS applauds the Government's recent decision to commence a trial of telephone-based psychological treatment via the ATAPS program in rural DGPs. A trial to specifically target intense support and treatment for people at risk of suicide or deliberate self-harm is also due to commence through the Better Outcomes program. The ATAPS program would also be well suited to specific Indigenous mental health initiatives, as the provision of services through DGPs can be tailored to more community focused and less formal, time-driven services.

However, routine mental health treatment provision, particularly in metropolitan areas, is less effectively provided through the Better Outcomes program in comparison to the Better Access initiative. A major issue is that a proportion of the funding for mental health services received by DGPs under the Better Outcomes program is spent on administering the program. The new Federal Government initiative for perinatal mental health will lose a significant proportion of available funds to administration by the DGPs as it is being implemented under the Better Outcomes program. Most importantly, the services will not be as universally available as they would be if delivered under Better Access.

Other concerns regarding Better Outcomes are associated with the under-qualified or administrative staff who manage the mental health programs in DGPs and are responsible for the selection and monitoring of ATAPS practitioners. Frequently more junior psychologists are selected to provide services as they attract lower salaries and allow funding for the program to go further, but this can put the quality of the service at risk. More expert psychology input is required in the selection and professional/clinical support of staff working under the ATAPS program of Better Outcomes. ATAPS should not be solely managed by Divisions, but should have input from a body like the APS to ensure quality of service provision. Whilst the APS supports the Better Outcomes program for targeted programs based on populations in special need, overall we believe that government mental health funding is more effectively and efficiently spent providing services through the Better Access initiative.