The Australian College of Specialist Psychologist met with Greens Senator Siewert, who has the Federal mental health portfolio, to discuss the concerns about the reduction of funding (cuts to Medicare) for the Better Access scheme. Below are the concerns we raised and our comments about the changes

## Concerns about the reduction in the number of session to specialist psychologists in the Better Access Scheme

The Australian Federal Budget was announced in May 2011 and a significant amount of money was provided for the mental health sector, to fund a number of new and current programs. What wasn't announced, was that the highly successful and sought after psychological services in the Better Access initiative was to be significantly cut. The number of Medicare funded specialist psychology services available were reduced in the Budget from 12 (and up to 18 sessions) to 6 (and up to 10 sessions). When the Better Access initiative was introduced in 2006, the scheme was seen as a major achievement in providing community based psychological services to a very large sector of people with moderate to severe psychological disorders. This was highly utilised by the community as it was the first time they had real possibilities to access evidence based, non-drug therapies. To quote a section from the Government funded Better Access Review, which was released in April 2011,

"The Post Implementation Review found that the Better Access initiative has significantly increased access to affordable mental health services in the primary care sector and to many patients who previously could not afford these services, thereby meeting a previously unmet need..... This major mental health reform seems to have improved access to and outcomes from primary mental health care for people with moderate to severe common mental disorders..... **The MBS is the most effective and efficient means of providing this service."**

The Australian Psychology Society review of the Better Access initiative, supported these comments further when they found that of the surveyed psychologists (No. 2,106) it was reported that 72 per cent of clients 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."

**For the Federal Government to cut such an effective, efficient and sought after service is difficult to comprehend.**

# Arguments used to cut the number of psychological sessions in the Better Access initiative

## 1. Costs of the Better Access initiative

The Post-Implementation Review run by the Department of Health and Aging concluded form their analysis of costs that the costs for treatment for depression and/or anxiety by Psychologists in Better Access was on average $753.31. Previous work had estimated that optimal treatment for these disorders would costs about $1,100 (in 2010 dollars). **The Review concluded that on the basis of these figures, Better Access provides good value for money in terms of MBS costs to Government.**

It has also been raised previously that the higher than estimated expenditure in the Better Access initiative needs examination in order to see where cost savings, if that is required, can be made without reducing the proper access to psychological therapies.

Medicare statistics between 2006 and 2008 show that the preparation of GP Mental Health Care Plans (item no. 2710) costed the Federal Government 135.7 million dollars. The GP MHCP reviews (item no. 2712) costed 23.6 million dollars. The total psychological therapy costs of sessions provided by Clinical Psychologists (80010) were 108 million dollars and for focused psychological therapies 140.5 million dollars. This shows that the referral and review process, which does not provide any actual psychological care or therapy, consumed a significant proportion of the money expended. Whilst the current Federal Budget has reduced the expenditure on GP plans and reviews, if these costs were **totally** removed from the MBS by not requiring a GP referral and review to specialist Psychologists, the Government would save considerable money and could arguably not have to cut expenditure on the actual therapy at all. GP referrals and reviews are not a requirement by the biggest Health Insurer in WA (HBF) in order for their customers to claim Clinical Psychology services, therefore such a requirement should also be reviewed by the Federal Government.

Data in the Governments review of the Better Access initiative also found that the percentage of patients not receiving mental health services subsequent to a GP MHCP was significant and increased as the patient locations become more rural and remote. Of the urban patients who received a GP MHCP during 2007, **33.8 per cent** did not receive follow up MBS mental health services in the immediate subsequent 12 months, and **37.7 %** of patients in rural and **48.9%** in remote locations did not receive MBS mental health services. This indicates that a significant number of MHCP billed to the Government were of no value or at the very least were not utilised.

Another interesting factor is the difference in costs of MBS payments for a Psychiatrist consult (approx. $350) as compared with a specialist Psychologist (approx $118). Interestingly, there were no cuts to the number of Medicare funded sessions for a patient to see a Psychiatrist, which are approx 50 funded sessions per year as compared with now 6 sessions with a specialist Psychologist.

## 2. Less sessions are adequate for the proper assessment and care of patients seen by specialist Psychologists

It is unclear how the Federal Government made its decision as to the number of sessions they should fund. It could be argued that the Federal Government, with its significant funding of psychological therapy in the Better Access initiative, would be looking for significant positive outcomes (recovery and sustained recovery) for people with mental health disorders. It could certainly be viewed as unethical to fund a treatment process which does not provide adequate care to the person entering this treatment

Research evidence should be very important in guiding policy making on such issues. An Australian study by Harnett, O'Donovan & Lambert, in 2010 aimed to estimate the number of sessions of psychotherapy needed for clients suffering from psychiatric illness (the majority were patients diagnosed with depression, anxiety, or adjustment disorders), to return to a normal state of functioning and for this to be reliable improvement. The progress of 125 clients entering psychological treatment in two university post graduate training clinics was tracked on a session-by-session basis. Recovery and reliable improvement were outcomes used to estimate the number of weekly treatment sessions needed to meet criteria. It was found that it would take about 8 sessions for 50% of clients to show **reliable improvement** and 21 sessions for about 85% to meet this criterion. **Recovery** took more treatment, with 50% of clients estimated to recover after 14 sessions and 70% requiring 23. The authors concluded that "On the basis of the present results we conclude that the present policy of the Australian Government in both the public and private sector regarding the number of sessions needed for clients entering psychological treatments to show a benefit is much less than is, in fact, necessary. The findings of the current study are roughly consistent with those found elsewhere and suggest a minimum benefit should be closer to 20 sessions. They concluded that "**The current (Government) policy appears to be suitable for only about one-third of clients who carry the burden of psychological illness."**

Another study conducted by the National Institute of Mental Health involving 250 clients who had received 16 sessions of psychological therapy, found that both CBT and Interpersonal therapy work equally effectively over the same period of time for major depressive disorder by comparison to SSRI medical treatment. Follow-up research of the study found however that around 33% of the sample relapsed within 18 months. The chief researchers who headed up the study stated: **"The major finding of this study is that 16 weeks of these specific forms of treatment is insufficient for most patients to achieve full recovery and lasting remission."** This aligns with the findings and recommendations of Harnett et al. (2010) mentioned above.

**Federal Government Better Access Review**

Although during 2007 and 2008 it was found that most patients (nearly 74 per cent) accessing Better Access allied mental health items only claimed between 1 to 6 services, this should not be used as the criterion to base a decision as to how many sessions need to be funded. The reviewers of the initiative actually stated that **" this low claiming rate could be attributed, in part, to patients who have commenced a mental health care plan towards the end of the calendar year and have not claimed many subsequent services within that calendar year".**

***There were no recommendations in the Review saying that the number of sessions to specialist Psychologists or Psychologists should be cut.***

**APS Better Access Review**
This review found different results showing 47% of clients were reported to access services beyond 10 sessions of treatment and over 60% of clients needed more than 6 sessions. The implication is that around half of people will need more than the 10 sessions of therapy being offered under the new proposals, and the majority will need more than the 6 sessions approved of by the initial referral.

## 3. Definition of "short term" interventions

The Federal Government defined the purpose of the Better Access MBS items to be utilised for **short-term interventions and treatment** of patients diagnosed with a mental health disorder. Therefore a comparative look at how another Governments defines "short term care" is worth examining. The German Government and insurers for example, since 2000 provide full payment of Clinical Psychologist's services (they do not fund psychologists who only have undergraduate training, unlike in Australia). **25 sessions is defined as short term therapy**, 45 sessions is defined as standard long term therapy (e.g. to treat a medium complex, medium severe depression) and payments can to be extended by 15 sessions to a total of 60 sessions.

## 4. Better Access specialist psychologists typically see patients with "mild to moderate" high prevalent psychological disorders (depression and anxiety) and more support is needed for people with moderate to severe disorders.

## This is not supported in the reviews of the Better Access initiative

- **From the Federal Government review of Better Access (N=606 clients)**
  The Better Access review found that more than 90% of people using psychological services had a diagnosis of depression and/or anxiety. This compares with 13% of the general population. Around 80% of these patients reported high or very high levels of psychological distress, as assessed by a GP given questionnaire at referral point. This compares with 10% of the general population. These figures are supported by several independent studies of the Better Access services where over half had severe mental health disorders as opposed to mild or moderate disorders (2007 National Survey of Mental Health and Wellbeing). In addition 45.5% reported a high level of disability as measured by the World Health Organisation Disability Assessment Schedule.

- **Australian Psychological Society research of the Better Access initiative (N=2106 psychologists)**

  The APS conducted its own review of the Better Access initiative and found o**ver 80%** of clients were reported as presenting with moderate to severe levels of symptom severity. A smaller number of people (less than 20%) presented with mild symptoms.

## 5. People who are disadvantaged in their access to mental health care are not getting services

**Federal Government Better Access Review**

The Review found that although some groups have had greater levels of uptake of Better Access than others, Better Access has reached all groups, and increased most dramatically for those who have been disadvantaged in the past. Children aged 0-14yrs and people in rural and remote areas had lower uptake than other groups but had greater percentage increases in uptake than other groups. The study found that the pattern was also consistent for those in the most socio-economically disadvantaged groups.

If funding is being shifted into the ATAPS scheme to support more services to rural and remote areas and disadvantaged people, along with the funding for tele-services, it is unclear why the number of sessions needs to be cut to Better Access when it is already doing its job well and actually providing a percentage increase to these groups as well. Rather than Better Access not working for these groups, it would be more likely that there are workforce issues and distribution of workforce issues, much the same as for medical services. Workforce issues should not be dealt with by cutting a highly valuable and functioning program.

It is also concerning when the reduction in the number of MBS supported sessions has been targeted for psychologists only, even though the level of service to, for example rural and remote areas, is similar for both specialist Psychologists and Psychiatrists.

## 6. ATAPS

The ATAPS program funded through the Divisions of General Practice, was established prior to the Better Access initiative. It will be currently funded via the Medicare Locals being established around the country. The Better Access initiative was reportedly viewed by the Government as complementary to the ATAPS program, and the ATAPs program was going to be refocused towards rural and regional areas, with a particular focus on low socioeconomic and Indigenous people. This was apparently in recognition of the lack of private health providers in these areas. This scheme was not designed to replace or compete with the Better Access initiative. Unfortunately however the Federal Budget has now shifted significant funding into the ATAPS program, while the Better Access funding has been significantly cut. This is in a situation where there has been no guarantees that the money funded to Medicare Locals for mental health services will be quarantined for mental health services, how it will be decided funding will be distributed, what level of training and skill providers will be required to have, and what work conditions will be given to providers of psychological services. The latter two factors will significantly affect the sort of providers which will be attracted to work in the scheme and the sort of people the Medicare Locals will choose to employ, having then a direct effect on the quality of care offered to the public.

Interestingly, the fees for mental health services in the ATAPS program to date, was funded by the Commonwealth at generally higher levels than those provided by Medicare.

Author: Dr. Jillian Horton jhorton@iprimus.com.au

# Executive summary of the Post-implementation Review of the Better Access initiative overseen by the Department of Health and Aging

This summative evaluation draws on data from 20 sources to examine whether Better Access has improved access to mental health care, has provided an effective (and cost-effective) model of service delivery, and has changed the profile and operation of Australia's mental health workforce. Each of these data sources has strengths and weaknesses but collectively they provide a picture of the achievements of Better Access. There is good evidence that Better Access has improved access to mental health care for people with common mental disorders. Uptake of Better Access services has been high in absolute terms, even among relatively disadvantaged groups in the community. Better Access is not just catering to people who were already in receipt of care and/or who have relatively mild symptoms; it is reaching significant numbers of people who have not previously accessed mental health care; and it is providing treatment for people who have severe symptoms and debilitating levels of distress. Consumers are generally positive about Better Access as a model of service delivery and they appreciate the clinical care they have received. They are also reporting positive outcomes as assessed by reductions on standardised measures of psychological distress, depression, anxiety and stress. In the main, these outcomes are related to clinical and treatment factors rather than socio-demographic characteristics.

Preliminary analysis of outcome and cost data for consumers seen by psychologists through Better Access suggests that the initiative is providing good value for money; equivalent data were not available for consumers seen by other provider groups. These achievements do not seem to be occurring at the expense of other parts of the mental health system. The numbers of allied health professionals in public mental health services have continued to rise, despite the attraction of working as private practitioners in the primary mental health care sector. In fact, Better Access may have had a positive effect on the way in which the Australian mental health workforce operates, with some indications that providers are engaging in more collaborative care.

These achievements should not be under-estimated. Good mental health is important to the capacity of individuals to lead a fulfilling life (e.g., by studying, working, pursing leisure interests, making housing choices, having meaningful relationships with family and friends, and participating in social and community activities). This major mental health reform seems to have improved access to and outcomes from primary mental health care for people with moderate to severe common mental disorders.

**Please also read the 11 page extended summary of the Post-implementation review as this contains all the data from the above and highlights that the Federal Government is totally ignoring its own findings and is aiming to cut a highly effective and cost effective program.**