28 July 2011

Dear Senate Committee,

I am a Registered Psychologist in Brisbane who has been working in private practice for 5 years. During that time I have completed work under Medicare and ATAPS programs.

The Medicare registration and approval process for providers numbers is very efficient and requires only a Mental Health Care Plan from the GP which is given to the patient. They can book in straight away and be seen in a timely fashion. The Psychologist can also be paid at the time of service as do GP's, psychiatrists, Physiotherapists, and most allied health get paid on the day of service.

The ATAPS program requires additional paperwork from the GP, who advises the patient they are approved for the program. No paperwork is given to the Psychologist. We are unable to book the client until we gain purchase orders from the Divisions of General Practice. The patient in this case can wait up to 4 weeks or so for us to receive the purchase orders and then we can book the client in. This process and referral type is very slow and cumbersome and would utilize additional funding to pay the Medicare Locals as they are now called, for organizing purchase orders and registrations of referrals from GP's, and processing payments via a third party. There is also a delay in the payment to the psychologist and from past experience we are always chasing these payments beyond 30 to 60 days. The duty of care to the client and timeliness of the service particularly those with chronic cases where their symptoms are severe and require immediate attention, is lacking under this referral system.

I think the funding should not be shifted into ATAPS, but remain in the Medicare system for ease to all parties (GP's, Psychologists and the mentally unwell clients) and to provide timely and quality mental health services.

With regard to the government's claims that under the Medicare scheme we do not see chronic cases is false. 1 /3 of my current clients have chronic cases. I have several clients who I have been seeing weekly to fortnightly between 1 and 3 years. These types of clientele almost always use their 18 sessions and really need at least 26 sessions per calendar (i.e; 1 per fortnight) or their condition worsens and deteriorates. Additionally when they have periods of fluctuations in their condition or suicidalituy, sessions may need to increase to 2 a week.

By reducing the number of sessions to 10 a calendar year is of great concern to my clients and it has also formed part of our discussions in sessions of late to plan for the gap from 1 November 2011 until 1 January 2011 when they can access counselling again.

I appose the changes based on duty of care at least to my current clients. I am not able to meet my ethical and professional responsibilities as a psychologist with these imposed changes with regard for duty of care for clients and for future chronic cases.

Please take my points into consideration

Regards

Kristie Clarke

Registered Psychologist