Committee Secretary
Senate Standing Committees on Community Affairs

Dear Committee Secretary,

RE: IMPACT OF PROPOSED NEW MEDICARE SAFETY NET- UNFORESEEN COLLATERAL DAMAGE TO THE MOST TRAUMATISED AND ABUSED.

I am a Fellow of the Royal Australian and New Zealand College of Psychiatrists and a member of the Faculty of Psychotherapy, within the College. I write to you about the proposed Safety Net changes outlined in the Health Insurance Amendment Bill.

I and my colleagues are very concerned about the impact the new Safety Net proposals will have on patients who need long-term ongoing mental health treatment as many of these patients will find their health care with a psychiatrist unaffordable*.

This appears to be an unforeseen side effect of an across the board reduction in the safety net, surely not aimed at the Mental health population who will be affected. There is very little to be saved and a great deal to be lost – just when the rare resources required will be needed more than ever according to the anticipated findings of the Child Abuse Royal Commission and the rising general awareness of these problems.
A scant and hard earned set of skills will be lost because it will be far easier and more lucrative for the relatively few psychiatrists now engaged in this demanding work to do quick and easy assessments and to avoid the scrutiny & stigma implying they must be 'milking the system'. Further there is a diminishing pool of those dedicated to this incredibly difficult and demanding work.

If the new Safety Net is legislated a significant group of high need patients who require consultation with their psychiatrist more than once a week will lose the appropriate level of support provided by the current Safety Net arrangements. Many of these patients are poor and unable to work as a consequence of illness, and the intensive psychiatric help that they urgently need to re-build their lives will be lost under the new Safety Net. The consequences are potentially disastrous and costly to the community. In line with fees outlined in the Medicare Benefits Schedule (MBS), patients who see psychiatrist greater than 50 times per year have their rebate reduced by half. This, together with new measures in the Single Safety Net will likely result in a massively increased gap of $120 or more per session after 50 sessions This is unaffordable for most people, let alone those socioeconomically disadvantaged by their condition.

The Bill in its present form will adversely affect in these people in three main ways

1. Among the mentally ill there is a proportion of around 20% that are severely ill and require more intensive treatment but do not receive this in public sector nor are they catered for by primary care providers. Far less than 10% of psychiatrists are equipped to or willing to work with this population. Many advocates for primary intervention overlook this portion of the population. Item 319 will apply to apportion of these but the associated criteria require patients to be so severely disabled that it entirely misses a significant group of (barely)'walking wounded'. Many of these significantly ill are survivors of complex trauma including chronic depression adult survivors of childhood abuse and severe complex PTSD including severe personality disorders. Certainly not simply 'worried well'
2. Although thought of by health bureaucrats as chronic and treatment resistant (and hence long-term very costly management problems) they should be more accurately considered modality resistant because the ordinary modalities used including psychotropic medication, brief crisis interventions or crisis hospitalisations for self harm/suicide attempts make little or no impact as demonstrated by an extensive literature. Intensive psychotherapy on a twice plus weekly basis however has a significant evidence base which has grown over the recent decade (ironically largely omitted or overlooked in this circumstance(see below - J Shedler 2010 etc showing that these approaches not only work , they are cost saving in an ongoing way, during and beyond the few years the patients are in treatment. These significant cost savings are from significantly reduced days in hospital, fewer visits to Emergency departments, fewer GP visits, much improved work participation with reduced reliance on welfare etc. (Stevenson et al, 2005)
There is an out-dated perception these treatments go on endlessly without improvement but the clear evidence is that there are modern intensive psychotherapy modalities that cure, with lasting improvements(unlike the 'treatments as usual' mentioned above that just promote chronicity) .
International and local research shows about 30% of even the severe personality disorders no longer meet the diagnosis after one year intensive treatment and 2/3 are no long affected after 2 -3 years whereas those treated less intensively barely improve and many (up to 10%) end in suicide.
3. There are relatively few skilled trained psychiatrists who work with this population but they are regarded as the specialist group to whom the patients will be sent when shorter term psychiatric and psychology treatments fail. Rather than engaging in primary care / prevention measures which GPs and psychologists are rightly encouraged to provide (for the majority of patients with mental health issues who can be helped with less intensive therapies) they take on these more affected patients as they should. By restricting the safety net , these psychiatrists will be unable to provide the treatments that all other groups expect them to offer, often as a last resort. Indeed they will be encouraged to take on better remunerated simpler cases, and their hard earned expertise will vanish within a few years with no alternative therapists or services being available. Psychiatrists with this hard earned expertise often are the main teachers, trainers and clinical supervisors who through their expertise support and maintain many other nurse therapists, counsellors, psychologists,

psychiatrists and psychotherapists who work with these victims of abuse & trauma. These funding changes will erode, undermine and destroy the culture of these treatment approaches, leaving no-one to replace them.
In an era when the spotlight is belatedly being turned on mental health and particularly on survivors of complex trauma and abuse it seems incredible that the relatively few psychiatrists willing to work in this area will be discouraged from working with these patients because of these spurious short-term cost savings.

Please consider how amendments to the proposed Act and the existing Medicare Item number schedules can prevent these impacts.

Yours sincerely

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