

06/07/2011

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

The Community Affairs References Committee,

Re: Committee Hearing to occur 16/08/2011
Consumer Response

This document is tendered pursuant to notice of motion referred to the Community Affairs References Committee for inquiry and report by 16 August 2011 with respect to Government's funding and administration of mental health services in Australia.

It includes reference to the following matters, to which I wish to express my concerns and provide my own recommendations as a clinician in the community.

I have been made aware that the Committee is due to review Government's 2011-12 Budget changes relating to mental health – specifically changes to the Medicare Better Access Initiative that affect the role of the GP, sessions, rebate structure and amendments to alternative pathways for those with mild-moderate disorders vs. those classified as having 'severe' disorders.

Please find my response and recommendations to the aforementioned:

- 1) The Better Access to Mental Health initiative has been to most successful community initiative to emerge in Australia. The number of people accessing psychology has been astounding and should be supported, not torn apart. GP's are receiving mental health support, with ongoing clinical contact that makes their management of mild, moderate and severe mental health disorders easier. Medicare should be supporting this, not changing it.
 - 2) The planned reduction to a 6+4 session model is severely limiting. Should high-risk and complex psychiatric cases (which I personally specialise – as many others refuse to treat) be limited to a 10-session cap per calendar year, I feel it would significantly increase risk of relapse, hospitalisation, self-harm, and suicide. A 10-session model, although understandable for approximately 85% of cases seen by Clinical Psychologists in the community, should also include 'special consideration', in which these cases I speak of easily meet criteria and should not be discriminated against. And setting the model at 10 would indeed discriminate those who require high-level assistance.
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- 3) A 12-session model should remain, with the addition 6 (a total of 18/year) having very significant and beneficial impacts on these patients. It is true that not all patients need this, but for those that do, Medicare rebates allow them to access affordable care. Discriminate against these marginalised individuals – who are often unemployed, disabled, homeless, or victims of domestic violence, etc. – and the Government runs the risk of these individuals ending up in Public Hospital beds or deceased.
 - 4) Rebates should remain differentiated between ‘clinical’ and ‘general’, for the simple fact that clinical psychology is a Masters-level qualification and thus a certain standard, higher education, training and expertise has been attained. Generalist Psychologists may not have had the necessary training or expertise; should these be clarified by either assessment or examination (something the APS might need to employ), they may be apply for the higher rebate. Regardless, a standard (and likely lower) rebate would restrict the number of seriously mentally-ill patients to engage with Psychology. Bulk billing would be non-existent and therefore the marginalised socioeconomic groups would remain marginalised.
 - 5) A higher rebate means that patients are able to access services, and that not only high income patients deserve interventions. The statistics show an overwhelming percentage of patients from low socioeconomic backgrounds have the highest incidents of stress, ongoing mental health, family mental health, substance use and social instability – these are the patients that Medicare should be supporting, and not alienating.
 - 6) Should this issue of income be a factor, Medicare should consider a means-tested approach to rebates – this would be more equitable for all.
 - 7) With reference to referrals, I would like to propose removing the GP Mental Health Care Plan and reviews (6-sessions). Removing these would free up funds for actual sessions and funds. Referral should occur just like any other specialty. A referral letter (including Provider Number) should be sufficient, and no need to return to the GP for 6-session reviews. Psychologists should still write a mandatory Doctors Letter and update, but should be allowed to see patients as they will, and liaise with GP’s and other services as they see fit.
 - 8) Psychiatrists may see a person 365 times within a calendar year, with fees approximately 4 times greater than Psychologists. All Psychologists are seeking is the ability to provide focused evidence-based care within a paradigm of 12-sessions, with the ability (should it be needed and can be justified) to go beyond with a maximum of 18/year. Certain disorders (e.g. Borderline Personality Disorder, self-harm, DID, anorexia nervosa) often require protracted number of sessions beyond 12 because of high risk factors and maintenance.
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- 9) I further recommend relaxation of the mandatory 50 minutes time period. A Psychologist, should they require it, be able to see a patient for an undetermined period (like Medical Doctors), and billing to be likewise; should a patient require a 30 minute maintenance appointment, the clinician should be able bill them so, and the Medicare rebate reflect the change in hourly rate (just like GP's). The mandatory 50 minutes, although commonly the time period for consultations, should be relaxed.
 - a. Psychologists, like other specialists in their fields, should be trusted to consult with patients for durations based on clinical determination, not the Medicare system per se. Billing should occur based on 15 or 30 minute time intervals, rather than 50 minutes.
 - 10) I believe ATAPS needs to remain, but its use needs to be heavily policed, inasmuch that it should only be reserved for low-income, unemployed and marginalised individuals, and not individuals from households with joint incomes of >\$80K/year – this is misuse of Government funds.
 - 11) I reserve strong doubts as to the effectiveness of the anticipated future handling of ATAPS. At present, this kind of referral is reserved for the low-income earners, and not based on any psychiatric eligibility. I struggle to see how ATAPS intends to be used strictly for those high-end patients. I believe it will be misused for everyday general referrals, and thus funding will be spent much more rapidly that it is anticipated.
 - 12) Reserving ATAPS for the extreme cases is also not realistic. A GP cannot establish the severity on initial consultation, and often these 'high-level' cases are complex with multiple comorbidities. Yes, ATAPS would benefit this patient group, but I have my reservations about how effective a system would be to allocate these specific individuals to an ATAPS referral as opposed to Medicare, if the GP does not have the training/experience in identifying these key issues.
 - 13) ATAPS should remain as an option only for marginalised patients to seek the necessary care.
 - 14) Both Medicare and ATAPS should have the same session system – the permitted maximum, including 'special consideration', should it be required.
 - 15) The current Medicare CPD should be retained (10 points/year), however clarification of what is considered 'acceptable' needs to be made. Merging with APS/AHPRA systems needs to occur. In addition, CPD for Medicare needs to be in line with the start/end dates as with APS/AHPRA.
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I urge the committee to based any decisions on the ideas and concerns expressed by clinical practitioners – not academics. I feel that a serious lack of ‘real world’ input has resulted in a warped Medicare and AHPRA system. At the clinical ‘coal face’, these patients are real and require sometimes little, but sometimes much special attention and treatment.

Summary

- **Do not make these individuals – who are often poor, in socially-isolating or averse situations, with complex morbidities – pay for a system who is allegedly helping them, but really limiting them.**
- **Consider continuation of the 12+6 session system, and not invoking the 6+4 system. I urge the committee to reflect the referral pathway system, allowing for GP’s to simply write a referral letter (and therefore removing the Mental Health Care Plan), and allowing Psychologists to see patients as long as deemed appropriate.**
- **A two-tiered rebate system should remain as it differentiates those with different levels of expertise and specialisation. The system should be treating Psychologists like Medical Practitioners (i.e. GP, Specialist, etc).**
- **Timed sessions should become more realistic and reflective of how GP’s bill (in 15 or 30 minute increments) – remove the 50 minute clause. ATAPS should remain, but should serve for low socioeconomic group.**
- **ATAPS cannot adequate be made for the ‘high’ or extreme cases, as it will not be likely to be employed correctly. Low socioeconomic patients should be the only recipients of ATAPS.**

I hope this document is accepted by the committee and discussed.

I believe it a serious issue that needs clarification.. It is the responsibility of the committee to serve the greater community, and by altering and reducing the availability of Psychological services to the community will be a disservice and result in more hospital admissions.

Sincerely,

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