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Submission with regard to the Senate Inquiry into Commonwealth funding and administration of mental health services

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My name is Wilfred Lax. I have been a Clinical Psychologist since 1985 and I have practiced in Australia since 1993. I am the CEO of Uplift Psychological Services, a FULLY BULK BILLED psychology practice with locations in Redfern, Mascot and Edgecliff in Sydney. We currently employ 28 Psychologists (the equivalent of 17 full time psychologists). We book in excess of 400 sessions per week. The bulk of our clients are un (or under) employed. Approximately 30% of them are of Aboriginal or Torres Strait Island descent. A large proportion are of NESB backgrounds. They include some of the most underprivileged (homeless) and severe diagnostic categories. Very few of them would be able to fund treatment under any other payment regime.

We are existing proof of how private enterprise using Medicare in a bulk billing environment is able to provide cost efficient services to populations in need. I am confident that our penetration and trust within the Aboriginal community exceeds any current government initiative. I am also confident that as a provider of last resort we provide service to many clients missed or unable to be treated by community health. I am also confident that we are more cost efficient and effective than Headspace.

We bulk bill exclusively and so are fully dependent on the Medicare rebates. We do see some ATAPS clients and are registered for the early childhood intervention scheme. I perceive the new proposed cuts however, to be very limiting and detrimental to the needs of the chronic and impoverished populations we see.

I would like to address the following issues:

I would like to make the general submission that the primary driver of these cuts would appear to be budget considerations and:

1. The costs needs to be weighed against the savings delivered in:

    1. People obtaining work
    2. Children remaining at school
    3. Marriages saved (legal cost/emotional)
    4. People coming off medication
    5. People remaining at work
    6. Clients not being hospitalised and more

2. Savings can be generated by many other means than those proposed:
    1. Having a 6 sessions general referral (self referral)
    2. Having a means-tested maximum session referral
    3. Having treatment length determined by client diagnosis and chronicity (with specific diagnostic requirements to be met.)
    4. Only involving GP's or psychiatrists if clients need to exceed the 6 session basic program.
    5. Excluding certain 'worried well" diagnoses, or limiting them to 6 sessions.

Comments about the cuts to Medicare

1 The ten sessions proposed are completely inadequate to the needs of the complex cases. They are sometimes also completely inadequate to manage very simple cases. Many life events that precipitate psychological treatment -.divorce or injury, and many diagnoses e.g. addictions take more time in real time to resolve than 10 or 20 weeks. Seeing clients every three weeks or monthly in order to fit them into a ten-session regime is not effective

2 Many of the clients seen under Medicare who have previously not been able to access Any meaningful psychological services have serious chronic and longstanding problems. Many of them have never seen psychologists before. They are often fragile and from vulnerable sectors of the community. They need long term psychological support as well as Focused Psychological strategies- sometimes a second problem can emerge within the 12-month referral cycle and the sessions will be exhausted and no provision made for further treatment. The current 18-session system is barely adequate for many of them.

3 It is more sensible to have service provision driven by client need rather than by pure economics. The random and arbitrary decision of ten sessions has no clinical rationale at all. The statistics appear to say most clients are not seen in excess of ten sessions and so it may be more meaningful to limit the numbers of people being referred by applying more rigorous entry criteria than by limiting the amount of sessions.

Comments with regard to the two-tier system

1. A four-year training is out of step with current standards in the rest of the world. The present writer (of South African origin) was trained in a six-year training system leading to a Masters Degree including a one-year internship. This system had been operating since the 1960's. The world standard and the Australian Standard is moving towards a Doctoral degree being the minimum. The four-year pathway should be abolished; it is 'third world' or less in its scope.
2. Psychologists with six-year degrees in Counseling or Educational Psychology should be given the same Medicare status as the Clinical Psychologist, but perhaps with more limited scope. They have in fact, adequate and proper training in their specialty to deserve more than generalist status.
3. All registered generalist psychologists should be called clinical registrants and be given a period to upgrade their qualifications/grandfather themselves at which point the four year qualification should be stopped. There have been attempts to do this, hampered by the fact that the bulk of APS members are generalist psychologists.
4. The Medicare system in this regard is driven by two conflicting needs. The need to have as many practitioners available to as many people as possible versus the need to limit costs. Proper professional treatment by appropriate professionals will ensure more effective treatment. The fact that consumers cannot distinguish between the two tiers does not imply any better or worse service.

Comments with regard to ATAPS

1. Under the present scheme the ATAPS system has been identical to that of Medicare for BULK BILLING psychologists. ATAPS has a slightly more difficult regime requiring some assessment and additional mandatory reporting. For General Practitioners the ATAPS scheme has had the advantage that those psychologists opting in agree to charge only the set fee. This forces the psychologist effectively to BULK BILL. Many ATAPS schemes do not distinguish between generalist and clinical psychologists thus offering an advantageously higher rebate to generalists and an incentive to opt in to ATAPS.
2. Many ATAPS clients have however, not been any poorer or more complex in their presentation than our ordinary bulk billed clients. The treatment offered has also not been any more cooperative or team based than other referrals. The referral paperwork is identical to that used by Medicare (2710-2712) as is the delivery.
3. The structures involved in running ATAPS (admin staff, room rentals, accounts staff, ATAPS officers) duplicates unnecessarily structures already existing in Medicare as each division has employees paid by ATAPS budgets to administer the scheme at no client service benefit this is a waste not a saving.
4. Many divisions operate schemes in which they have vested interests in making referrals to certain professionals and profits are made by the division from the ATAPS schemes. Referrals are not fairly distributed or even appropriately distributed because of the limits discussed in (5) below.
5. ATAPS schemes under their current guise are discriminatory/restrictive:
    i. Only Dr's registered with the scheme may refer within their division
    ii. Referrals are only made to psychologists registered with the scheme in their division.
    iii. As referrals can only be made within the division, the geographical logic of this is not clear, but many clients live in one division but see a GP in another, in Sydney many divisions cover a small area and clients are then forced to see another GP or another psychologist if they are to stay within a divisions rules.

In addition ATAPS budgets are currently severely restricted and often run out (after a month). Currently in the Central Sydney Division ATAPS referrals are limited to 50 per month. They have at least 50 psychologists registered. This is a pathetically small amount of people (600 per year) for such a large population and on this basis the 'expansion' of the system is in fact a severe contraction of the system. The details of how the ATAPS system will be an expansion or the budget allocated or the diagnoses to be seen have not been clarified. It would be necessary to clarify the working of the system (if it is to be implemented) so as not to duplicate the Medicare sessions but to in fact enhance or expand it.

I have many other thoughts on these matters and would be available to discuss them in person if required.

Yours faithfully

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