Submission to the Senate Inquiry into Funding and Adminsitration of Mental Health Services

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- The rationalisation of GP mental health services and allied health services will have a significant negative impact on optimal management of patient care
- Currently I bulkbill about 80- 90% of mental health consultations (ie item 2713) due to he financial constraints on many patients with such condtions with a majority of my more severely affected patients unable to work due to their condition
- I bulkbill all my mental health care plans- ie 2710 and reviews 2712
- Writing up the assessment/ plan and referral letter take a considerable amount of after consulting time (non face to face time) with longer less remunerated standard consult items- ie item 36 and 44 services occurring
- The 2710 rebate went part way to better remunerating GPs for all the after hrs work often involved in care of such patients
- This after hours care includes crisis management outside routine appt times, liaising with psychologists and psychiatrists about individual patients, liasing with public mental health services, working with families, schools and communities. These are duties I usually undertake when the pt is not in the room and I am unable to bill medicare for provision of such services
- I feel I will have to look at limiting the number of patients that I bulkbill – such as any new mental health patients. Thus limiting access to good quality services.
- I am actually reconsidering how sustainable my current general practice career is into the future as I have a considerable number of mental health patients and these changes will mean increased workload for myself despite less remuneration.
- There will be decreased access to quality ongoing psychologist care and potential increased use of general practice services and crisis public mental health services
- An important aspect of Better Access and Better Outcomes initially has been the ability of the GP to refer to a specific psychologist with specific approach tailored to the individual patient. There are many different psychological therapies – some more some of use in all mental health conditions and others tailored to particular conditions. There is also a wide range of experience of psychologist in different mental health diagnoses.

- A diagnosis that often falls through the gaps in care is Borderline Personality Disorder (BPD). This is a chronic condition that I have read has a similar suicide rate to that of schizophrenia yet patients with this diagnosis are often not managed within the public local mental health system. These patients often require case management due to the high rate of crisis presentations and this “case

management" is often only provided by GPs. BPD has been thought of previously as being almost untreatable but various new therapy approaches render improvement possible. There is limited access to public health BPD treatment- a program called SPECTRUM in Victoria provides some care but their resources are limited to only those patients that are case managed by a local public mental health team. GP's cannot refer to that service themselves. As I previously stated patients with BPD are less likely than schizophrenia or Bipolar disorder to be case managed and so thses patients may miss out on accessible definitive care that can be life changing.

- Referral to private psychologists with an interest in BPD and the specific BPD therapies has been the most useful aspect of the Better Access program for my practice. I have several patients that are managing so much better than they have previously and their futures are now hopeful for a productive healthy life and relationships and in making a contribution to our society.
- Such patients often require ongoing therapy over many yrs with a trusted psychologist. My concern is with the new Medicare Locals provision of mental health care – that GP's will not have the choice of access to particular BPD specific interest psychologists and this not have the most appropriate care. BPD patients often have a history of significant childhood trauma and childhood sexual abuse. Their condition requires a very specialised approach- not just short term CBT or interpersonal therapy, but DBT as a specific therapy over several years.
- The limitation to number of sessions will severely compromise their care- most of my BPD patients have required the up to 18 sessions rebateable in special circumstances. How will Medicare Locals deliver such care top BPD patients if the psychologists they retain do not have such experience? I make this statement based on my experience of being restricted to using the psychologist from the local ATAPS funded and managed through the Divisions of General Practice service. There are patients that I feel would have been better referred to a different psychologist but due to the patients inability to meet the gap payment for the private psychologist they have seen the ATAPS provided. In some cases the limitations on options of different special interests of psychologists was detrimental to that patients care and may have turned them away from seeking appropriate psychological care in future.
- I know several psychologists that do see patients for no payment once the 18 sessions have been utilised. With the decrease now to 10 sessions the impact will be significant. Not only BPD pts themselves will suffer but so will their partners and children and extended family and friends due to the diminution of their care.
- I am sure provision of services to dual diagnoses patients with both mental health conditions and alcohol and drug misuse will be similarly affected.

- Another concern is the redirection of funding from GP and private allied health mental health services to Headspaces limits provision of that care to only those patients that live in close proximity to the Headspace clinic and such services are limited anyway to only 12-25 yo patients. I agree appropriate care and early

intervention in mental health conditions is most beneficial but it is limiting access to other age groups as it is taking away from the positive aspects of Better Access.

- I am also concerned that Headspace clinics will not be able to employ an adequate number of GPs to work in their clinics as the rebates for mental health plans and reviews is being decreased.
- Isn't it discriminatory that a mental health care plan has a much lower rebate than a General Practice Management Plan or Team Care Arrangement which are provided for physical conditions and are usually written up by the practice nurses. This is in comparison to the mental health care plans that I write up myself – in time after the consultation has ended.

I am certain the provision of mental health care can be improved. This redirection of funding though is not the answer.