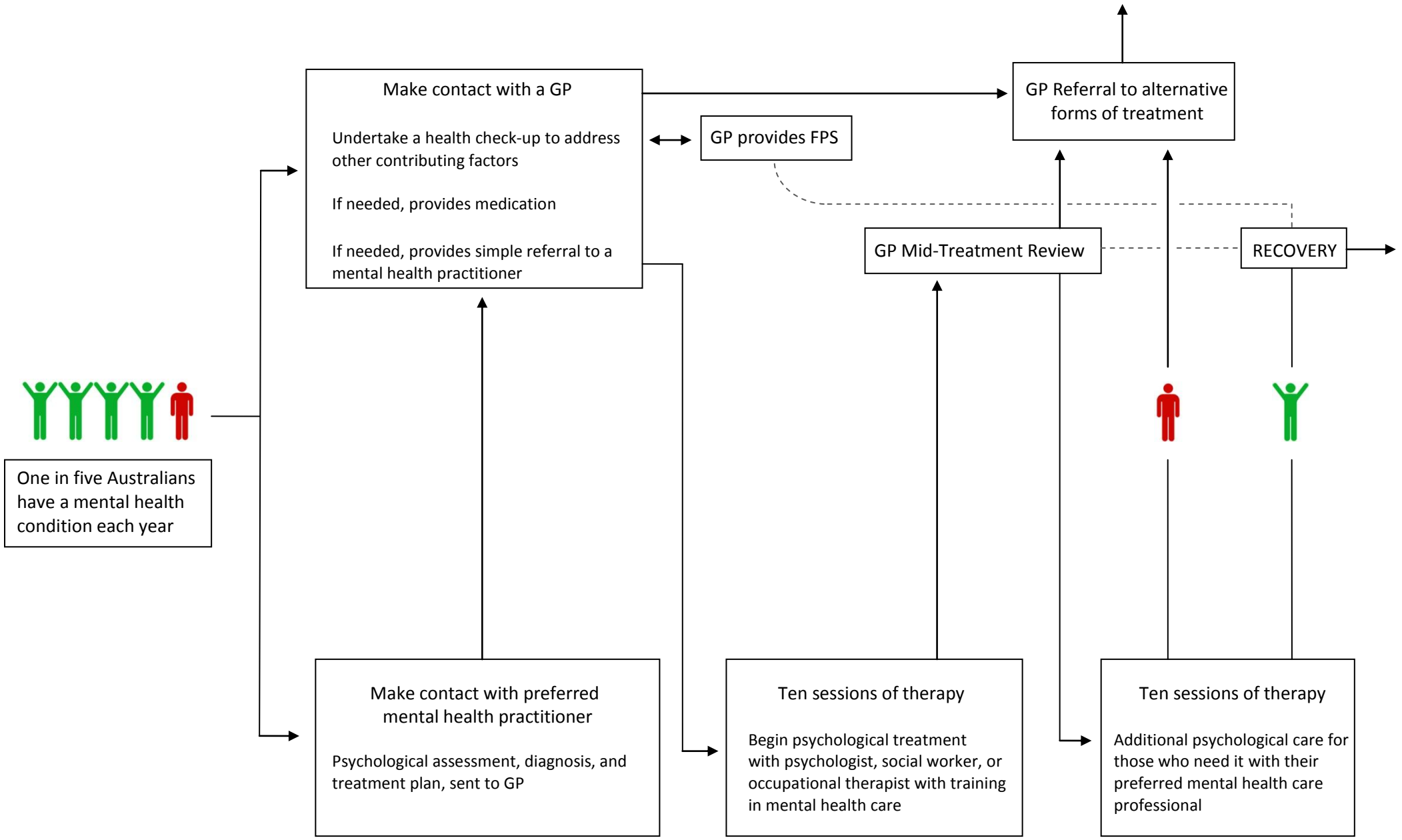
Make contact with a GP
Undertake a health check-up to address other contributing factors
If needed, provides medication
If needed, provides simple referral to a mental health practitioner
GP provides FPS
GP Referral to alternative forms of treatment
GP Mid-Treatment Review
RECOVERY
One in five Australians have a mental health condition each year
Make contact with preferred mental health practitioner
Psychological assessment, diagnosis, and treatment plan, sent to GP
Ten sessions of therapy
Begin psychological treatment with psychologist, social worker, or occupational therapist with training in mental health care
Ten sessions of therapy
Additional psychological care for those who need it with their preferred mental health care professional

Making Contact

This first point of contact is often a crucial one in mental health care. People can be confused and upset, looking for support with someone they trust, so it is important to make sure the system is simple, direct, and easy to follow. The revised model empowers mental health consumers to identify who they are most comfortable with right from the beginning.

Since 2006, the Better Access initiative has required a multiple page Mental Health Care Plan to be processed by a GP before a patient can access Medicare-supported psychological treatment. A key problem with this approach has been the additional time required by the GP to process the referral. In the new system it is proposed that this process is simplified to a standard GP consult with a plain referral to a mental health practitioner. This will require less paperwork, less obstructions for the patient, and will be easier for all parties to understand.

In many cases the first point of contact is with a mental health practitioner rather than a GP. In the past, those who seek Medicare-supported therapy have had to go back to their GP to start the process over again. The experience of being turned away from mental health care has led some people to withdraw from seeking help, particularly in cases of depression. The proposed new system allows people to start the process with a mental health professional that they trust.

In the new proposed system, a single appointment is made available for all Australians to access brief psychological assessment if needed, with its own MBS Item number. The mental health practitioner provides an assessment and treatment plan to the patient's GP, who then undertakes a health check-up to determine whether psychological treatment can proceed. This additional pathway allows the patient to identify their preferred therapist and will improve the quality of diagnosis and treatment. It allows those with the most training and experience in psychological assessment to carry out that function.

GP Provides FPS

In cases where a GP is qualified to provide psychological treatment, patients are able to access mental health care through 'focused psychological services' (FPS) in Medicare. In the proposed new model that option would remain in place to assist those who wish to receive psychological support with a trusted GP who has additional training in psychological treatment approaches.

Accessing 10 to 20 Appointments

In the prior system, access to psychological treatment has been capped at a maximum of 6 session intervals. This restriction was often cumbersome and costly for patients, who were required to go back and forth between a GP and their therapist to renew their Medicare referral. In the proposed new system, once the GP has approved a period of psychological treatment to proceed, the patient is then able to access ten sessions of uninterrupted care. If that patient requires more support from their GP, they will still be able to return as needed for a usual GP consult.

GP Mid-Treatment Review

When the Better Access initiative was launched in 2006, mental health practitioners sent written reports every 6 sessions. For the 80% of patients who access Medicare with complex conditions, or moderate to severe levels of distress, early reports often showed limited progress. At the beginning of 2012, this problem was compounded by changes to the system that required another review just 4 appointments after the first report. In both cases, the practical implication of these practices was that a patient needed to have multiple reports and reviews from their GP to receive the minimum recommended treatment (15 appointments). To reduce duplication of services, over-monitoring,

and excessive costs, the revised model only requires a mid-treatment review after 10 appointments. An additional advantage of this approach is that people who require more than 10 appointments are not categorised as being an 'exceptional' case, which has been a source of mental health stigma in the past.

Referral to Alternative Treatment Programs

Last year the Federal Government argued that funding for the Better Access initiative should be redirected to other forms of mental health treatment. In truth, very few other programs give people access to psychological treatment, particularly adults with a mental health condition. When other systems come into place however, it will be important that the Medicare system is flexible enough to integrate the care of a patient across other treatment and support services. The revised model allows GPs to refer patients on to alternative treatment programs at every point of contact with the patient. In particular, the revised model includes the ability to refer on in cases where a patient has used all of the available Medicare appointments and has still not recovered. This is an important addition to the system, because presently when a patient runs out of sessions they are not able to access psychological care via the ATAPS program. Our mental health care system must provide support for people who do not respond to initial stages of treatment.

Recovery

The revised model acknowledges that recovery can occur at any stage of the process. Processes of review create opportunities for people to reflect on their own progress and decide whether they wish to proceed. By removing some of the administrative barriers and focusing on a person's treatment needs, the new system puts people in control of their own recovery.

Costs Comparison

The revised model has been compared to the two models used both in 2012, and between 2006 and 2011.

At the 6 session mark, the new model arrives at savings of between $16.15 and $27.75 per patient. With over 916,700 Australians accessing Medicare supported psychological treatment each year, this represents an annual saving of between $14,804,705 and $25,438,425. Across 10 appointments, the savings increase to between $62.25 to $84.05 per patient, representing a potential annual saving to the Commonwealth of between $57,064,575 and $77,048,635. Even in the case of bringing the maximum treatment length to 20 appointments, the revised model only marginally increases Medicare costs for those cases.

This puts the current system in a difficult position to defend. If the Federal Government claims that patients only use 6 to 10 sessions, then our revised model will result in significant savings. The lesser proportion relying on Medicare support for further sessions will cost a small extra amount in those individual cases, but will deliver more appropriate levels of mental health care across the general population.