The impact of Item 319: De-identified clinical case studies

Below is a selection of problems communicated to NAPP by concerned clinicians - none are fictitious.

Psychiatrist 1

These people do not have the capacity to fight the changes to the rebate system, or if they do, they do not want to be identified as patients.

In my practice, there have been a wide variety of effects to the change in item number. In the beginning when item 319 was even more discriminatory, one of my patients, refused to allow me to reduce my fees, so that they could continue with twice weekly therapy. They were so furious, that after our session, they hit their car with their hand so hard that they sustained a fracture to the wrist. This required surgery and physiotherapy, and caused a lot of pain. It also meant that they were unable to work for 6 weeks. From a personal point of view it was a great problem. From a financial point of view it cost the government quite a lot of money.

I had another patient with Bipolar disorder. She did not qualify for item 319. She was discharged early from hospital, when she was still actively suicidal. She would not allow me to reduce my fee, and agreed to come only once per week to sessions. She committed suicide 6 weeks later. With cuts to the hospital system, so that severely ill patients such as these are discharged prematurely, and cuts to outpatient care, so that they cannot be seen adequately, this kind of problem will probably recur. I note that the major psychiatric illnesses do not fit into the 319 category, and therefore, when the hospital system does not see its own outpatients, private psychiatrists often cannot see them frequently enough.

Psychiatrist 2

Unfortunately, as I am carrying a fairly heavy load of half-fee sessions, I have to discriminate against patients who are unable to make a reasonable financial contribution. I regularly see patients who need more than once a week therapy, and would probably be able to use it, but as I cannot afford to subsidise them all I offer is to see them once a week, and pretend I feel that is all that is needed, when often I know they need more.

Psychiatrist 3

I am extremely grateful for the opportunity to feedback on the outcome of the Item 319 issue. Although only in practice since early this year I already have one patient out of my half time case load who now, after trials of CBT, medication and less intensive psychodynamic therapy has been qualifying for the item 319 but has only now wanted to proceed with billing at this item (after much time and discussion due to perceived stigma). I have several other current patients who have extremely long and complex psychiatric histories with long-term function that has been grossly affected by both Axis 1 and 2 pathology that cross-sectionally at time of assessment lay outside the GAF requirements and are therefore receiving less intensive treatment than they need or are about to begin carrying the burden of decreased rebate. I have another patient who is

terminating partly because of the cost of proceeding beyond the 50 sessions despite both Axis 1 and Axis 2 pathology and being in her twenties, at an age when early intervention is likely to make the most impact, but when patients are often least likely to be able to afford to subsidise their own treatment.

Hence my experience based on this current 6 months of treating patients is that a high percentage of my case load are impacted on by this issue and discriminated against by virtue of the definition of the 319 'gate' by both diagnosis and GAF and by the resulting intensification of stigma that already mitigates against presentation for acceptance of treatment. Furthermore this is happening at a time when CHCs are overloaded and the issues that might have normally been dealt with by case management such as accommodation, support of family and rehabilitation are not being picked up in the more severe patients. These issues are then left to be dealt with within a psychotherapy frame which is struggling to make headway in reduced sessions in any case. It is often seen that if these patients have a psychiatrist offering therapy then any more is "overservicing" when in reality some of these patients are being underserviced and are not receiving the biopsychosocial treatments that they require. In my current experience access to appropriate and necessary care is being compromised.

Psychiatrist 4

I do have a couple of patients in twice weekly, intensive, exploratory therapy. I have given up going through the GAF with them (I used to do this as a sort of informed consent), because they find it demeaning - it chokes the mill with grist to explain that they can only have twice weekly psychotherapy if they are more sick than a certain government determined level - they express fears that improvement will result in their premature expulsion from therapy, that the government will be monitoring their private affairs, that they will be responsible for their therapist being harassed by the government, etc.

So, in both these situations, I am forced to shoulder a burden of responsibility that puts me at risk - the Woods Royal Commission quite adequately demonstrated that manifestly unfair laws creates criminals of decent citizens - to give patients longer appointments puts me at risk of a charge of 'overservicing', to keep the entire decision about 319 eligibility from the patient creates a potential crisis of trust with the patient and leaves me unsupported if there ever is an audit of eligibility.

Trainee Psychiatrist

My name is T.P. I would like to add to any other comments by trainees about this crucial issue. I would feel comfortable that I speak for many trainees by adding that we believe this 319 business is another example of the government trying to introduce a quasi-managed care type arrangement where it would appear that the patient's needs are prioritised behind his funding restrictions. This can only serve to jeopardise optimal patient care, something to which every person is entitled. The other grave concern I have is that the ever-imposing shadow of government interventions savages the autonomy of our profession and the restrictions on psychotherapy benefits merely lead to this area of practice becoming less appealing. I believe this may have detrimental effects on trainees

electing to undertake further study in this important, and some may argue, already neglected field.

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