Senate Submission for Complex Dual Diagnosis Clients

By Greta Goldberg, Clinical, Forensic and Neuropsychologist, 4 August 2011

Proposal for an initial 3 year cycle of 20, 18, 10 sessions by Clinical Psychologists

In the last two months I have appeared as expert witness for several complex matters in the NSW Children's Court as well as in the NSW District Court, Juvenile Justice and also HCCC tribunals. On each occasion I have been cross-examined under oath, about my recommendations for "an ongoing counselling relationship of trust with a suitably trained and experienced Clinical Psychologist."

My reply in court is usually the same, even though each complex case is very different.

"From the viewpoints of the community and the particular client, long term clinical psychology interventions are the best, most cost-effective interventions for complex mental health needs when the client has multiple diagnoses and no possibility of self-funding."

The existing Medicare entitlement of 18 sessions in such complex cases has proved to be "almost enough time" for establishing a trusting clinical relationship that will enable clients to call on further counselling if they should need it in the following years because they have had the opportunity to see that such therapy has worked. In many of these cases, the treating Clinical Psychologists have also been happy to continue providing ongoing follow-up services for a "No Gap" fee.

The following are a few of the hundreds of case examples who have previously benefited from such recommended long-term therapy. Under the governments' proposed 10 session scheme, such complex clients will be inadequately supported, and therefore more likely to drift back to hospitals, refuges or jails at great expense. The reason for this is that the proposed 10 sessions could be used up within two months which for complex cases will be too little time for a working relationship of trust to become sufficiently established and whatever gains were made will be lost if a client has to wait 10 months for further sessions to be approved.

- One case example recently was in the Children's Court Care & Restoration matter disputing the removal of two infants because parenting capacity and restoration prospects were compromised by domestic violence and early childhood trauma as well as mild intellectual disability in the mother. In order to develop her skills and to mature emotionally, she needed to be able to access specialist counselling in a stable,

ongoing clinical relationship of trust, and for this to be able to continue after the departmental services have ceased.

Before the proposed Medicare funding cut, the clinician had a better chance to establish trust and also provide excellent follow-up with 18 more Medicare sessions every year when VCT or DoCS entitlements had run out. In this way, service providers have been informally cooperating to integrate services for the benefit of the client's mental health. This cooperation will now be undermined as service providers, both public and private, recognise the hopelessness of such a limited service for complex cases.

It seems obvious that the economic/psychosocial wisdom of supporting more effective coping to keep vulnerable individuals able to function autonomously within the community, would be a benefit to all.

- Another complex example involves a transgender male who, after years of chronic recidivism, is now determined to stay out of prison. To achieve this, he needs to be in an ongoing clinical relationship of trust to help sustain the new coping skills and reintegrate into society.

  Once again, before the proposed Medicare cuts, his Clinician could have provided excellent long-term follow-up of 18 sessions every year, thereby reducing the personal and community cost of returning to jail every few months, as before.

- Other cases involve several dual diagnosis Juveniles, aged from 12-17 whose initial therapy was funded by the department and has been able to continue under Medicare, to the benefit of the community and to the client's safe re-integration into his family, thus saving the government thousands of dollars by staying out of refuges and jails, and off social security.

- Private sector examples also abound, where severe bipolar or borderline individuals are being effectively treated by Clinical Psychologists and becoming more able to function autonomously because their major issues have been denial, distrust and isolation.

Clearly in complex dual diagnoses cases two months of 10 counselling sessions would be ineffectual, whereas 20 sessions in the first year, followed by 18 in the second year, and then 10 in the third year, makes much more intuitive sense for the long-term maintenance of mental health in dual-diagnosis patients.

At a recent conference at the APS College of Clinical Psychologists this month, I was asked to open a Q & A meeting on the subject using a Hypothetical in which the words 'Medical Practitioner' and 'Medical Specialist' were substituted for the words 'Psychologist' and 'Clinical Psychologist' in the statement put out by the Senate Community Affairs Committee. This is the hypothetical statement that opened the Q & A session:

"The Senate Community Affairs Committee has concluded that there are no grounds for the two-tiered Medicare rebate system for Medical Practitioners, and recommends a single lower rate for all Medical Practitioners, including Medical Specialists."

We opened the Q & A session with this hypothetical question:

"What would the AMA do if this threat was posed upon their members?"

Clearly, the greater power and resources of the AMA equates to their greater political influence and clout.

Let us remember, as educated thinking people, that mental illness is by and large caused by power abuse, in families and in society, and by poverty. Let us also remember that suitably trained and experienced Clinical Psychologists have, amongst their many other skills, the know-how and awareness to deconstruct that power abuse, both intra-psychically and psychosocially, thereby improving mental health and social functioning.

Therefore, it is most important that the Senate Committee should hear and dialogue with the Clinical Psychologist's submission, including the submission that I have put for 20, 18, 10 to become a three-year plan for the improved and more effective management of complex dual diagnosis patients.

Many of these patients have already utilised other mental health services including medication and departmentally-funded support. What they need in addition to that in order to create an excellent mental health system is reasonable access to the

development of an “ongoing therapeutic relationship of trust with a suitably trained and experienced Clinical Psychologist.”

To pretend that there is no distinction between the basic training of a psychologist and that of a member of the esteemed College of Clinical Psychologists of the APS is the equivalent of assuming that there is no distinction to be made between the local medical practitioner who writes your scripts and referrals, and the medical specialist, who, by virtue of his training and experience, undertakes more complex treatment programs.

Finally, we should remember that complex dual diagnosis mental illness is more slow and insidious in its development and needs a longer treatment time span as well as specialist trained Clinicians. Hence I propose a 3 year cycle of 20, 18, 10 sessions by a Clinical Psychologist in such cases.

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