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Committee Secretary
Senate Standing Committees on Community Affairs
PO BOX 6100
Parliament House
Canberra ACT 2600

Dear Committee Secretary

Re: Submission for Senate Community Affairs Committee into Commonwealth Funding and Administration of Mental Health Services.

This Submission has been prepared by Dr Jennifer Flatt (Clinical Psychologist).

Summary

I am writing to express my serious concerns about the changes the Government has made to the Better Access to Mental Health program. I would like to make it clear that my concerns are for those of my clients who will be seriously disadvantaged by these changes. I also think there are some general issues of importance in mental health care delivery in Australia.

I wish to make a submission to the committee that relates to the following specific areas of the committee's terms of reference.

Section b) part (iv) – Changes to the better access initiative including the impact of changes to the number of allied mental health treatment services for patients under the Medicare Benefits Schedule

And

Section e) part (i) – mental health workforce issues, including the two-tiered medicare rebate system for psychologists

The change to a maximum of 10 sessions per calendar year

1. Effect on those with severe mental illness

I practise as a clinical psychologist in two locations: Lilyfield in Sydney's inner west; and Blackheath, 120km from Sydney in the upper blue mountains. In both locations, but

especially in Blackheath, I see a number of patients with severe chronic mental illnesses such as Bipolar I disorder, schizophrenia and personality disorders. In the upper blue mountains psychiatrists are in short supply and there are also only a few clinical psychologists, to whom the psychiatrists tend to refer the most difficult patients. Public mental health services are stretched. The ATAPS program in this area employs mostly generalist psychologists, social workers and counsellors who do not have advanced training in treating severe mental illness and who are restricted, appropriately, to focused psychological strategies. Virtually all of my patients with severe mental illnesses or complex presentations will have had more than 10 sessions by 31 October 2011. What will happen then? If I do nothing, at least a few of these people will no doubt gain entry to the public sector by being hospitalized in the last two months of the year because they will break down; one or two would probably attempt suicide and, if they survive, gain at least short-term access to public mental health care. These people have complex problems and often a history of difficult experiences in the mental health system. They often have great difficulty trusting a mental health professional. The relationship between psychologist and client has been built up over time. It won't easily just transfer to some new person, even if such a person was available. The alternative would be that I continue to see these people without charge. I can do this, but I don't think it is reasonable that psychologists should have to do this, and it's also not helpful for patients, who see themselves then as "charity cases" or "problems" and some of whom may well decide that they will not attend free sessions anyway, sometimes with disastrous results both personally for the patient – bad enough – and, for the Government, the financially costly result of hospitalisation.

Going forward, I think the solution to this problem will be that, although I am trained and experienced in dealing with this group of people, I will be ethically bound to decline these referrals because it would not be responsible for me to take on someone with a severe problem and build a relationship with them in the knowledge that I can offer them only ten sessions.

2. Effect on those with Mild to Moderate presentations

Some people of course do have problems that can be successfully treated in 10 sessions or less (although the research on evidence-based best practice would suggest that at least 15 sessions is needed for effective treatment of even simple presentations of anxiety and depression). Other patients have the financial means to pay for extra sessions if they need them. There are however a substantial number of people with mild to moderate problems who do not fall in either of these categories. I bulk bill more than half my patients. These are people who are: Health Care card holders; low income earners; moderate income earners but with high expenses such as children to support; anyone else whose GP recommends they should be bulk billed. People with fewer financial resources tend to live with higher levels of stress and tend to have more severe problems and more comorbidities. They also tend to have an increased incidence of negative life events which change their circumstances and retard their progress. Again, I suspect the solution going forward will have to be that I, and all those other well trained and experienced clinical psychologists, will not be able to accept these referrals because of the potential to do harm by having to stop treatment prematurely. Where will these people go? Not to private psychiatrists, there are too few and many too few who bulk bill. Not to ATAPS, because these people need more than focused psychological strategies. Not to the public mental health system because their presentations won't be severe enough. At least not at first, although without treatment some may develop problems that are severe enough to gain entry to the public mental health service. We will go back to the future and once again these people will go without treatment.

Can I stress that this really is not about my income or my status. Like most clinical psychologists, I have more than enough work to keep me busy regardless of the number of sessions covered by Medicare. I had a successful private practice for more than ten years before Medicare for psychologists was introduced. I will just return to seeing people who can afford my fees for the number of sessions they need. Affluent patients also will not suffer – they will just pay for the number of sessions they need. The people who will suffer are the severely mentally ill and the people with mild to moderate problems without the financial resources to pay for themselves; that is, the most vulnerable people will suffer.

Removing the two-tiered Medicare rebate for psychologists

Of course people who have acquired appropriate training should be recognized for the special skills they have gained. It is important for consumers and their GPs that they can differentiate between levels of skill in the psychological workforce and it is important for practitioners that specialization is recognized as it is in other areas of work.

The real issue here is about the training of psychologists. Something like 80% of people currently working as psychologists in Australia could not work under that title in any other English-speaking country. We are lagging behind the rest of the developed world in the standards we require for people to intervene in the psychological wellbeing of other people. It really is pretty important that those who intrude into other people's emotional life know what they are doing

If you doubt that a 4-year University degree is inadequate for unsupervised practice as a psychologist, have a look at the course content. A typical 4-year degree gives good coverage of psychological theory, scientific methodology, experience in conducting and evaluating research and the ability to carry out and understand statistical analysis. It's a good foundation for working out which treatments are evidence based and which are not and it provides a good grounding in psychological theory and the theoretical side to psychological practice. It typically does not provide even a course in basic counseling skills, let alone practice in applying clinical techniques. Clinical training, usually via a Clinical Masters degree and 2 additional years of intensive University study, provides what you need to work with clients. For most of us, even those who have already practised as a generalist psychologist for years, it's a huge learning curve. It's a very demanding course from which we learn masses of useful information and skills. It informs everything we do as clinicians.

Training opportunities

We need to open the doors of clinical training opportunity to those psychologists who have not had the benefit of this. We need to make access to these courses much easier, and we need to stop basing entry on academic performance, which is largely irrelevant to being a good clinician. We need to make these courses financially affordable – the people who get the training will pay our community back with good mental health care. We probably also need to remove the heavy research component from these courses, so they can be more fully focused on acquiring relevant clinical skills.

