4 August 2011

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.

I would like to speak to the following terms of reference

(b) (iv) the impact of changes to the number of allied mental health treatment services for patients with mild or moderate mental illness under the Medicare Benefits Schedule

(e) (i) the two-tiered Medicare rebate system for psychologists,

Professional Background:

I am a clinical psychologist with a 25 year history of working in community based mental health services both within child/adolescent/family and adult mental health teams in disadvantaged areas of Sydney. In 1994 I was regraded to Senior Clinical Psychologist in recognition of my specialist skills in the area of dissociative disorders and complex trauma, publications and supervision of staff and clinical psychology interns. For 15 of those years, from 1995, I have worked part-time (50%) in the public sector and part-time (50%) in private practice. Last year I finally resigned from public sector work and increased my private practice load to full time.

I believe I may have something useful to say about the proposed changes listed above.

With regard to:

(b) (iv) reducing the number of Medicare rebated sessions from a possible 18 down to 10 sessions per calendar year

As a Clinical Psychologist who rarely treats patients with mental health problems which are less than moderate to severe, finding ways to ethically provide treatment within an allocated maximum 18 sessions per year has been very challenging. Outcome research in the more complex clinical presentations indicates that treatment usually takes years. Published research evaluating the effectiveness of psychological treatments of for example, “borderline personality disorder”, usually involves treatment trials of at least weekly

therapy for many months to more than a year. The "International Society for the Study of Trauma and Dissociation" specifically states in their treatment guidelines for "Dissociative Identity Disorder" (which has a prevalence of 1-3% in the general population, with afflicted individuals presenting frequently to public mental health services) "treatment takes years not months".

Suggestions that the solution for clients needing more than 10 sessions is to refer them to the public mental health system, or psychiatry or ATAPS does not make sense and flies in the face of the facts. As someone who has 25 years experience in the public mental health sector at a senior level I believe I can speak with some authority in relation to the inability of community based public mental health services to provide treatment for the clients seen under the Better Access Scheme requiring more than 10 sessions of treatment per calendar year.

Historically, the types of clients seen via the Better Access Scheme ***were*** able to access psychological services through the Public System. The system changed in the mid to late 1980's with the Richmond Report, which recommended moving people out of psychiatric wards to be cared for in the community. This was followed by a rationalization of existing community based mental health services to cope with this demand, and in my experience, clinical psychologists were expected to stop servicing the types of clients who are currently seen under the Better Access Initiative.

Clinical Psychologists employed in community based public adult mental health teams are few in number. In the inner city Sydney based service I was employed in, I was the only clinical psychologist on staff and then, only on a part-time (2-3 days per week) basis. The core business of clinical psychologists in the public community based adult mental health system, despite their job descriptions, is rarely the provision of face to face treatment services for individuals with moderate to severe mental health conditions.

Clinical Psychologists in the public system are expected to spend an average about 25% of their time doing Intake/triage, the same as their psychiatric nurse co-workers and spend many hours per week on administration tasks, attending clinical meetings and undergoing staff development in areas often unrelated to the provision of clinical services such as attending fire drills and learning manual handling tasks more appropriate to hospital based nursing staff. They are expected to see around 4 to 5 clients per day and don't offer after-hours appointments.

The clients of public sector community based Adult Mental Health clinical psychologists are usually unemployed, live in public housing and are in receipt of welfare, usually disability, payments. The client load of the clinical psychologist usually includes chronically ill patients with psychosis, similar to their psychiatric nurse case manager colleagues. Because Clinical Psychologists constitute a minority profession in public community based mental health, they constantly have to assert their right to function as specialists rather than generic case

managers due to the low staff to patient ratios. Their duties with these patients can overlap with the work done by psychiatric nurse case managers and in addition to the provision of clinical psychology assessment and treatment services, can include, depending on the culture of the particular service team, nursing type case management interventions. The non-psychosis type clients on the clinical psychologist's caseloads usually have very severe chronic and complex disorders which include disturbances of personality functioning, pathological dissociative reactions, severe drug/alcohol abuse and recurrent suicidality to name but a few of the more common scenarios.

These clients have usually managed to successfully access the public system because they have first been hospitalised due to a suicide attempt. Most individuals presenting to a public sector mental health facility via intake/triage, who don't have a chronic psychosis based problem, unless they are suicidal and/or lack a Medicare card due to residency/visa issues are immediately referred to the private sector.

Deciding to refer to a Psychiatrist just because a patient needs more than 10 sessions and can't afford to pay for additional sessions is unethical. This amounts to acting as though Psychiatrists are interchangeable with Clinical Psychologists and negates the fact that both are distinct professions each with their own unique and complimentary contributions to treating mental health issues. In other words, one profession does not substitute for the other. Additionally, the severity of the patient's presentation, the duration of treatment or their ability to afford treatment is not an appropriate determinant in deciding which profession to refer to. Furthermore, Psychiatrists are in short supply; hence usually have long waiting lists, and not many of them bulkbill.

In relation to ATAPS, we once again face the ethical issue of inappropriate referral. By definition, individuals requiring more than 10 sessions of treatment are likely to have more severe issues. They need access to psychologists with higher levels of experience who are also free to choose evidence based treatments suited to more complex clinical presentations. Under the current arrangement, ATAPS providers are limited to the use of focussed psychological strategies. Focussed psychological strategies represent a skill set which can be taught to non-psychologists such as GP's which are not the evidence based treatments of choice as the core aspects of any treatment plan with individuals presenting with problems of more than mild to somewhat moderate levels of severity. Additionally, focussed psychological strategies are not a substitute for accurate clinical formulation of a client's problems leading to appropriate treatment plans.

In summary: Clinical Psychologists are uniquely placed to appropriately treat the clients currently accessing the Better Access Program. Cuts to the number of sessions funded by Medicare will mean that only patients who can afford to pay for additional sessions will be able to continue treatment. Proffered alternatives for patients requiring more than 10 sessions of treatment per calendar year have the ring of a "let them eat cake attitude" and do not represent adequate, ethical or realistic solutions for those who cannot afford to pay

to complete treatment. Sessions should remain as they are or preferably, increased. The requirements for the additional 6 “exceptional circumstances” sessions should be relaxed given the evidence based reality that successful treatment for anything more than mild problems with a client who is successfully engaged in the treatment process usually takes more than 12 sessions.

With regard to:

(e) (i) the two-tiered Medicare rebate system for psychologists

This issue seems to have arisen because “The Evaluation of the Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule (May, 2011) survey” indicated that there was no evidence for a difference between clinical psychologists and generalist psychologists. On the basis of this survey an argument has been made that the rebate for endorsed clinical psychologists and the psychologists who don’t have this endorsement should be the same.

The “survey” referred to above, contained serious methodological flaws and its findings would not survive serious scientific scrutiny. To infer that the data collected in this survey provides “proof” that all psychologists are the same is offensive; purely because the ***quality*** of the “proof” that is being quoted to justify this conclusion renders it unscientific.

The division between “clinical psychologists” and “psychologists” has been a problem in Australia for decades. Unlike the rest of the civilized world, in Australia anyone could call themselves a psychologist, even those without a degree in psychology up until the arrival of psychologists’ registration around 1990. I commenced my professional life as a 4 year university trained psychologist in the 1980’s. I obtained membership of the Australian Psychological Society after completing 2 years of “supervision”. I commenced a Master’s degree in Clinical Psychology in the 1980’s because back then it was difficult to get a job in the public sector without a postgraduate degree in clinical psychology. At that time, these degrees were and still are very difficult to gain entry into. Unfortunately, in Australia, we have a situation where to be called a psychologist you do not need a post graduate degree after completion of your 4 year undergraduate degree and your chances of getting a place into a clinical post graduate degree even if you wanted to, are slim. Hence the majority of registered psychologists in Australia are not endorsed as clinical psychologists.

Because of the above, I believe that the current 2 tier system debate has galvanized an old issue. I see from the other submissions that many cases have been made for both sides of the argument as to whether clinical psychologists are more effective or are the same as other psychologists.

The argument that says “we are the same” is based on the “outcomes” from the methodologically flawed “The Evaluation of the Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule (May, 2011) survey”, and the “lack of any evidence to say there is a difference” argument. However, “lack of evidence” does not prove something does not exist. In the same vein, it’s likely that no evidence exists that current medical training leads to better doctors than medical training in the 1950’s. Some of this research is just not done when a need is not deemed to exist. Internationally, I imagine there was no need to see if there was a difference between psychologists with or without post graduate degrees because psychologists without post graduate degrees just didn’t exist in other western countries. The argument to say “we are not the same” comes from the fact Clinical Psychologists have an additional degree and that their training more closely matches international standards of training.

I think to “solve” the issue by removing the 2 tier system, which interestingly, translates into lowering the rebate as opposed to increasing it, is problematic. Why? Well for one thing, it means I will no longer be able to afford to bulk bill my poorer clients because I will not be able to afford to pay the rent on my office if I do. I think the current debate over the 2 tier system hides a bigger issue. To say that having a clinical postgraduate degree does not improve the quality of a psychologist’s clinical skills is counterintuitive and supports the notion that the “lowest common denominator” sets the standard, or alternatively, dare I say it, gives credence to “the tall poppy syndrome”. At the same time, not renumerating the specialist skills of those who have additional training, especially post graduate training in other endorsed areas of psychology is unfair.

In summary: My recommendation would be to leave the 2 tier system in place and establish protocols for more fairly renumerating psychologists for any additional post-graduate psychology qualifications/endorsements they may have relevant to providing services under the Better Access Scheme.

Nick Cocco
BSc (Psych) Hons; MA (Hons) (ClinPsych)
Clinical Psychologist