Rose Cumberland

Clinical Psychologist

To Whom it May Concern,

I am writing this submission regarding the federal government's proposed Budgetary changes to the Mental Health, with particular reference to the impact upon patients accessing psychological services.

My name is Rose Cumberland, and I am a Clinical Psychologist, currently working part-time in a Sydney public hospital, and part-time in private practise. I specialise in working with those with more severe mental illness, and work in rooms with Psychiatrists with whom I work closely to achieve the best possible outcomes for my patients. I have 10 years experience in the field of psychology, and have spent time training to be a registered psychologist before I undertook my post-graduate training in Clinical Psychology.

With regards to the Terms of Reference:

b) ii) & d) i)

I am concerned that rationalisation of services provided by allied health providers means that there will be a diminishment of the rebates available for those accessing more skilled and more highly qualified professionals such as clinical psychologists. I work with GPs who will only refer to clinical psychologists because of our additional training (in most cases 4 years in addition to that completed by registered psychologists), enhanced proficiency at diagnosis, and capability handling complex clients including those at risk of suicide. I also work with Psychiatrists who preferentially refer to clinical psychologists because of our ability to manage clients with complex and severe illness, skills which are unfortunately not taught in a structured way to most registered psychologists. I currently supervise a student psychologist-in-training to be a registered psychologist and a good deal of our work together is focusing on the need to refer on more complex clients to more highly trained clinicians. It is impossible to train someone in an hour a week for two years what clinical psychologists learn whilst studying a 2 year full-time post-graduate masters degree, incorporating coursework, clinical placement, and advanced research. With that said, I have been concerned that some clinicians providing medicare items have not had sufficient experience in the field prior to providing mental health items. I would be happy to see Medicare become more stringent in their requirements regarding experience after training for both clinical psychologists and registered psychologists.

I admit that in the general population there is a lack of understanding of the differences between clinical psychologists and psychologists, however this difference is increasingly being recognised in the hospital system, as was recognised by the Medicare tiered rebates. It is most certainly recognised in the outpatient mental health services sector, where as aforementioned, most Psychiatrists and General Practitioners that I work with will only refer to clinical psychologists, knowing that we provide a better service to those most in need (with more complex/severe problems). I would hypothesise that a survey of General Practioners and Psychiatrists referring

patients under mental health care plans would support the differential rebate system for social workers, psychologists and clinical psychologists.

b) iv) & d)

I am deeply concerned that the “rationalisation” of allied health services, particularly the reduction of access to clinical psychology services for those with severe illness, has been cut from up to 18 sessions per year (under exceptional circumstances) to only 10. The notion that only people with mild or moderate illnesses are treated under this scheme is simply quite wrong, at least in my experience. My patients have often received inpatient psychiatric treatment, crisis intervention services, or made suicide attempts prior to (and sometimes during) our involvement. The majority of the people I see (upwards of 80%) would, at initial assessment classify as suffering from a severe mental illness with scores in the Extremely Severe range on the Depression, Anxiety and Stress Scale.

Working with complex cases as I do, a number of my clients have required more than 10 sessions to achieve full remission from their complex problems. Some clients with ongoing or chronic disorders such as Major Depression, Eating Disorders, Bipolar Disorder, severe or complex Anxiety Disorders, Post Traumatic Stress Disorder, and Borderline Personality Disorder require more sessions to focus on skills and reduce their risk of suicide and/or hospital admission (thus overall reducing cost to the public hospital system and minimising bed block). As aforementioned, many of these patients have had short-term involvement with public mental health services and many have been discharged from these services to my care. When I worked with younger people in the Headspace initiative on the Central Coast, discharging patients from our service (which offered assertive case management for moderate to severely mentally unwell young people) was often enabled because we could send them to competent and skilled private practitioners for ongoing follow-up. I know this to also be the case working in the public hospital system (such as in medical rehabilitation where I now work), where people often suffer comorbid mental health complaints as part of their major medical illness. I simply would not be able to provide an effective and efficient service to all the clients that present, and the private resources available help to take the pressure off an already stretched mental health system. I am concerned that reducing access to private clinical psychology services in particular, by cutting sessions will cause access block in the mental health services, and whilst the ATAPS funding is welcome, it seems clear that these services are not available in all areas (where I practise privately in northern Sydney area there is no ATAPS program), meaning that there will be unequal access across health areas to people requiring psychology input.

With regards to cutting sessions, I am concerned that ethically, there will be a diminished capacity for skilled clinical psychologists in the private sector to take on more complex cases, particularly if they are financially stretched, given that the chances are that they will require input beyond the 10 rebatable sessions. This poses significant problems for equal access to service, and in my private practise there is a sliding scale of fees for those on disability payments or in financial pressure. I have made this decision because patients with severe or complex illnesses are often affected occupationally and hence financially by their problems. It is, in my view, potentially damaging for those with complex mental health problems to engage with a therapist whom they will be unable to continue therapy with. As it stands with up to 18 sessions available, this is much more feasible (though some clients will still require further input). Clinicians with firm ethical practise will now potentially be

unable to take on the more severe cases due to the cuts in number of rebatable sessions, thus placing the mental system under further (undue) pressure.

I would like to point out that in private practise, a vastly increased number of patients can be seen as compared with in the public sector. In a standard (full) day in the private sector I am able to see up to 10 patients, enabling many more people to receive access to mental health care. In the public sector, due to meetings, staff responsibilities, case management concerns, and administrative duties, in a standard day I would often see a maximum of 5 patients. I feel that the medicare rebate system as it stands enables a greater number of patients in need to access services in a faster, more efficient, and more cost efficient manner.

Summary

Whilst the proposed extra mental health services announced under the federal government's budget are welcome, cutting funding to much-needed psychological services, particularly to clinical psychology items, seems to be a serious concern. Whilst it is clearly based on assumptions such as "those accessing services are only mildly or moderately affected by mental illness" and "those receiving psychology items gain benefit in only 10 sessions" I cannot help but compare this to my own experience which is starkly in contrast to these assumptions.

I propose that the existing system prior to the 2011 budget be upheld in order to maintain equal and efficient access for patients with all types of mental illness, but especially those that are moderately to severely unwell. If the changes are implemented, I would foresee increased pressure on existing public mental health services (without private clinicians to discharge to), increased bed blockages (and inpatient hospital costs) in psychiatric hospital services (with diminished psychological assistance that has been proven to reduce hospital admissions), and a reduction in the ability of those that are severely unwell to access skilled clinicians who may be ethically compromised in taking on clients who require more than the 10 rebatable sessions. I would further reason that reduced access to early intervention in the form of psychological assistance (often more easy to access in the private sector), may result in patients presenting with more severe illness that has been left untreated for longer. Economically it does not seem to make sense to make cuts to these services, compassionately it seems to penalise the most unwell, and rationally it seems to be implementing blanket changes that could be more efficiently streamlined using more stringent criterion for those accessing "extra" or additional services.

I would naturally be happy to discuss these further should you wish to contact me on . I am also contactable on

Sincerely and with some hope,

Rose Cumberland

Clinical Psychologist
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