Submission to Senate Committee re funding Mental Health:

I work as the Discipline Senior Clinical Psychologist in an Adelaide Mental health Service AND as a part time private psychologist in an independent practice. In both arenas I am known as a therapist who has expertise with clients with severe mental illness, in particular with Borderline Personality Disorder (BPD). This is a widespread (1+% of people) and very costly disorder due to the frequency of self harm, ED presentations, mental health service utilisation and GP presentations. Such clients make up about 30% of my private clients and it has been possible to provide evidence-based effective treatment for them by utilising the Medicare provisions of up to 18 appointments for these "difficult to treat" clients.

My public service work has included establishing Dialectical Behavior Therapy (DBT) based group programs and Intensive DBT programs for a few very severe clients. The combination of SA Health based group program and individual DBT therapy has proved effective in terms of symptomatic improvement, but especially in terms of reduction in service utilisation (inpatient days, ED presentations). This evaluation was published in the Australian professional journal *Behaviour Change* in March 2011.

SA public mental health services lack both the resources and the expertise to provide the DBT individual therapy component and private practitioners are unable to bear the cost of providing a 20 week program of 2+ hours of weekly DBT skills training with 2 facilitators as required by this group of clients. Therefore the success of this partnership between public DBT group provision and private DBT individual therapy provision will be threatened by the proposed changes to the maximum number of appointments rebated by Medicare.

In addition to this I also treat many clients referred to me with severe mental disorder. I include clients with Obsessive Compulsive Disorder, severe Social Phobia and severe Depression in this group. The nature of their disability means they are unlikely to be able to articulate their point of view. However, they will suffer.

In recent years my position has mean that I have come to know a fair bit about the publicly provided Psychology services and the GP Division programs. The GP Division programs have drifted down from a motivated start to employing less trained and qualified staff. Locally they have developed "soft edge" group programs and seen clients with less severe disorders. Locally they offered meditation and relaxation groups, mothers group and generalised "stress" and

“anxiety and depression” groups. They have refused to take on clients with Borderline Personality Disorder, citing (correctly) their lack of clinical skills. Clinical Psychologists employed by the public mental health services are appropriately qualified but are often inexperienced and would be unable to manage the demand due to their scarcity.

In recent weeks the issue of the “two tier system” of Clinical and Generalist psychologists has come to the attention of the Senate Committee. It is unfortunate that this has deflected the emphasis from the benefit of our clients.

However, this is a matter of some concern given the efforts of the Psychology profession to raise the quality of services provided by Psychologists. My experience in several voluntary positions (The Australian Association of Cognitive and Behavioural Therapy and the SA Section of the APS College of Clinical Psychologists where I have designed and delivered the Continuing Professional Development seminar program for SA Psychologists for about 5 years) has led me to believe that there is a case to retain this division with incentives for general psychologists to acquire the extra training to meet the higher standards for Clinical endorsement. These standards are easier to meet than when I undertook the study and 2 years of clinical experience followed by 2 years of Clinical Supervision required ten years ago (well before Medicare rebates).

I have continued to teach at University level in the Clinical Master and Doctrate training programs and I have seen a few “generalist” psychologists undertaking this training, and displaying their own lack of previously acquired knowledge and skills in the process. Many generalist psychologists consider that they practise in the same way because they do not know what they do not yet know. I have taken over the care of clients “treated” with hypnosis, relaxation therapy, energy therapy, meditation, detailed talks about childhood experiences and hardships, and similar ineffective contacts. For example, one client was referred to me with Borderline Personality Disorder (which he did not have) by a generalist psychologist who had billed Workcover fortnightly for 2 years with no discernable improvement. She had not helped him become independent, nor detected his malingering.

I hope that you will consider my opinion on these two issues associated with the current Senate Inquiry.