

Commonwealth Funding and Administration of Mental Health Services

Senate Inquiry: Community Affairs References Committee

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Introduction

As a practicing clinical psychologist I am regularly confronted by the lack of services that are available for individuals suffering more chronic, advanced levels of psychopathology. I work primarily with clients suffering Borderline Personality Disorder (BPD), a severe psychiatric condition effecting approx. 2% of the population. In hospital settings clients with BPD account for approx. 16% of inpatients (at significant cost to Medicare). BPD is a treatable condition, using evidence-based treatments such as Dialectical Behaviour Therapy (DBT), of which I am specially trained to administer. The clients I see present with protracted histories of abuse, self-harm, suicide attempts and fractured interpersonal relationships. I am writing to the senate enquiry to express my concerns about 3 main issues. I will set these out along with recommendations.

1. Ethical considerations

My concern with the recently proposed changes to the Better Access Scheme is that clients requiring specialist services will be greatly disadvantaged. DBT is a minimum 12-mth commitment, with over 3 hours of therapy contact a week. The results for clients who engage with this treatment are clinically and statistically significant. Within 12-mths we see significant reductions in hospital admissions, suicide attempts and self-harm (significant savings for Medicare). We also see significant improvements in self-care, distress tolerance and emotion regulation. Since I have been delivering DBT, the vast majority of my clients have been eligible for the "exceptional circumstances" provisions due to the unstable nature of their condition. Yet, even with 18 sessions, many clients are not able to complete the program in a succinct and efficient way. Many have to wait months for their mental health care plan to resume in order to resume treatment. In that time, some clients are able to maintain individual sessions monthly, others simply have to wait. What frustrates me as a treating professional is that I've often seen clients go "off the grid" during these breaks, where they feel abandoned by the system that initial offered a hope of help and assistance.

I feel constantly torn as a clinical psychologist as to my ethical position here. Is it ethical that I commence a treatment (which the research, and my experience shows is effective) when for many the costs involved are just not practical? One might be saying to themselves "why don't these clients go into the public system?" Short answer: they can't. In Melbourne where I practice there are three public health services that I am aware of for people with Personality Disorders. All of these services are reserved for the extremely severe end of the spectrum (i.e., daily self-harm, frequent suicide attempts, extreme labile emotion). Not all clients with BPD present in such an extreme manner, due to a number of factors such as relationship and financial support to name but a few. The majority of my clients are not

severe enough to be accepted into the public system, and so they turn to the private system. If clinical psychologists like me are struggling to deliver an evidence-based treatment with a max of 18 sessions, how on earth are we expected to do our job with only 10? It's simply not achievable, and I fear that for some clients, they will no doubt demonstrate a worsening of their symptoms in order to receive the help they require from the public system. Most outcome studies demonstrate that at least 20 – 25 sessions are required to achieve clinically significant change.

Change however, is not always linear. Some clients may come for 12 sessions, reach a level of functioning again, only to be hit down again by a life stressor, and require assistance once more to get back on their feet. As a psychologist in the private sector, I either don't get paid in order to help my clients, or tell them they need to find the money first. That's not a nice position to be placed in.

2. Disproportionate distribution of budget money

The next issue I would like to raise is in relation to the investment the government is making in early intervention. The government is investing a significant amount of money in "early intervention" programs such as EPIC and headspace. Whilst I applaud the focus on this area of the community, I have to say that the amount of funds that these programs are receiving are disproportionate to the prevalence rates of the conditions they target. For example, the EPIC program targets first episode psychosis. Schizophrenia has less than a 1% prevalence rating in the community. Why so much funding for such a small group. In order to fund these programs, the government is reducing access to private allied health workers like social workers and psychologists, and reducing the rebated referring GPs can claim. I am not suggesting early intervention is not important, it's that there are many other people who require help who will miss out as a result. A more balanced budget approach is required.

3. The review process

Under the current Better Access Scheme, psychologists are required to write review letters to the referring GP after each block of 6-sessions. The rationale for this is so that the GP can "monitor" the allied health worker's work, and ensure the clients are receiving the best care. Whilst I agree there are some who require such supervision, I don't believe post-graduate trained clinical psychologists should require this degree of supervision.

Other than psychiatry, Clinical Psychology is the only mental health profession whose complete post-graduate training is in the area of mental health. Furthermore, it is the only discipline whose complete training is in psychology, that is, both at the undergraduate and post-graduate level. In other words, the Clinical Psychologist is completely trained in a science intrinsic to mental health (1998, Work Value Document, Western Australia Clinical Psychology Health Sector, p.30). For this reason it seems unreasonable why the work of clinical psychologists need to be monitored in such a way.

Recommendation:

- Increase individual and group session allocation for clinical psychologist to at least 24 sessions per calendar.
- Remove the need for "review" sessions for clinical psychologists.