

2nd August, 2011

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

Submission to Senate Community Affairs Committees regarding the Government's funding and administration of mental health services in Australia

I am a Clinical Psychologist who has worked in SA state government community mental health for nearly 20-years, and in private practice in a rural region of South Australia for the past 7-years. I am also a proud member of the Australian Psychological Society Clinical College in South Australia, and I will not be intimidated by rogue elements of the profession who are wilfully interfering with an open and transparent submission process for this current Senate Inquiry. I wish to openly and honestly submit my personal comments to the committee for your consideration, using your terms of reference as topic headers for comment:

(a) the Government's 2011-12 Budget changes relating to mental health;

I applaud additional monies into mental health. In South Australia reform has been slow due to the lack of state government priority for mental health, the subsequent lack of funding allocation, and many missed opportunities in Commonwealth initiatives from various bi-partisan Mental Health Strategies. I recall national early psychosis funding initiatives in the mid-1990's, not taken up. Now 15-years later specialist early psychosis services will finally happen here, but only because the Commonwealth is "taking over". I really feel for the many young people and families who have missed out on appropriate specialist care during this time. I currently work in rural SA so am very supportive of initiatives to better address the availability of mental health services in rural and remote regions of SA. It is a topic of discussion at our upcoming SA Rural and Remote Psychology Conference on 9th September. I also work in a rural high school and see the need and benefits of early intervention strategies. So as you can gather, I am certainly not opposed to mental health reform and recent budget initiatives, but I do wish to express some concerns for your consideration and response.

(b) Changes to the Better Access Initiative, including:

(i) the rationalisation of general practitioner (GP) mental health services,

GPs are doing a fantastic job in primary care in assessing client need and direction into various pathways including mental health. They are required to summarise physical and medical assessments, and undertake a mental state examination, risk assessment, functional capacity and preliminary diagnosis to assist with referral pathways. If they have completed additional mental health training, I believe they should be financially rewarded above a beyond a time related consult. What is also lacking though is a clear understanding of referral options, including state mental health, ATAPS, psychology or focused psychological strategies, as well as specialist options of psychiatry and clinical psychology. These need to be marketed better and clear and consistent pathways established.

(ii) the rationalisation of allied health treatment sessions,

As I implied earlier, the lack of funding and consideration of mental health has led to gross underservicing over a number of years in South Australia. The introduction of Better Access provided new service options, and that is why we have witnessed an uptake beyond expectations, but also an unplanned consequence that low prevalence disorders and severe and complex cases were being referred to private psychologists, along with ongoing GP support. To wrestle this back now using an economic sledgehammer approach (reduction in treatment sessions from 18 to 10) may well lead to a return to service denial for those in great need, as well the potential for undertreatment of clients with severe mental health problems and functional disability. From my clinical experience, clients receiving more than 10 sessions often have a significant mental illness (OCD, PTSD, Psychotic Illness etc), co-morbidity (drug and alcohol misuse, personality disorder, social needs,) or complexity (past trauma, relationship issues, cultural diversity), and heightened risk (self harm, suicidal, abuse). Clinical research and meta-analysis findings have informed our clinical guidelines and recommend appropriate frequency and duration of clinical psychology therapy. For example:

If you have had PTSD for more than 3 months you should be offered a course of trauma focused psychological treatment (CBT or EMDR). These treatments should normally be provided on an individual outpatient basis. If you have experienced a single trauma, a course of treatment is likely to be 12-24 sessions, usually lasting for 60–90 minutes each. It may be necessary to have more than 12 sessions of treatment if you have experienced the traumatic death of a relative or friend, if the trauma has resulted in a long-term problem or disability, or if you have lived through a series of traumatic events.

Psychotherapy treatment for PTSD, by Harold Cohen

Linehan developed a year-long time-limited therapy for borderline personality disorder which “emphasized the management of emotional trauma” and consisted of three components; one hour individual sessions addressing client progress and needs, 150 minute group sessions for skills training, and constant telephone access to the primary therapist by the client for emergency situations.

Linehan et al., 2006

Exposure and response prevention ERP usually involves 15 to 20 exposure sessions that last about 90 minutes. Cognitive therapy is usually done over the course of 15 to 20 sessions, although the cognitive therapy sessions are often shorter in duration, lasting 50 to 60 minutes.

Psychological Therapy for OCD, by Owen Kelly

The sledgehammer approach from the recent budget of reducing treatment sessions may work economically, but not clinically. Often these clients recover well with an appropriate amount of quality therapy. As highlighted above, clinical research is demonstrating effective treatment for borderline personality disorders (48 sessions, Linehan), post traumatic stress disorder (12-24 sessions), obsessive compulsive disorders (15-20 sessions), and various severe and complex disorders. These trials are usually conducted by experienced clinical psychologists applying manualised treatment protocols. Why not consider some additional specific Medicare Item numbers claimed only by specialist clinicians for treating specific diagnoses using specified treatment interventions? Please consider the client costs not just the economic costs.

(iii) the impact of changes to the Medicare rebates and the two-tiered rebate structure

The two-tiered rebate system for psychologists recognises the post graduate qualifications, clinical experience and ongoing professional development of clinical psychologists who have met the criteria for clinical endorsement with the Australian Health Practitioner Regulation Agency. They are usually members of a professional body who adhere to strict codes of ethical and professional practice. The ongoing recognition of these professional standards must be maintained to better regulate the profession, and ensure these standards become the benchmark for psychologists into the future, with the referring doctor and client having confidence that they are receiving effective, evidence-based treatments for the identified mental health issues.

(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;

My own clinical work, and the recent evaluation of services provided through Better Access, clearly demonstrates that clients utilising these services have clinical symptoms from moderate to extremely severe levels. This is the reality of current service provision. If the Government is seeking to re-design services, such that those with severe and more disabling illnesses receive services through State Mental Health and Medicare Local ATAPS, there needs to be professional changes and greater clinical governance over these services. Most clinical psychologists and psychiatrists are in private practice. They have the best skill set to treat severe and complex mental illness. But they will need to be lured back into these systems by consultancy options, supervision services, clinical training and greater financial recognition. These systems must also contribute to the profession by making post-graduate clinical placements available within each and every Medicare local.

(c) the impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program;

I have worked with ATAPS programmes in the past through a Division of General Practice. In 2001, 94% of clinicians were psychologists. As the service grew the KPIs sought were client contact per dollar spent. Mental health nurses, social workers and inexperienced psychologists were recruited. Clinical effectiveness became secondary, and clinical psychologists and psychiatrists were no longer required as they were seen to be too expensive. In many regions, psychology is now below 10% of staffing. If this is the future system you want for clients with severe and complex needs, please continue. If you wish to create an effective system, please ensure an appropriate discipline mix, quality supervision, ongoing professional development, student placements, and the purchase in of additional individual and group programme expertise.

(d) services available for people with severe mental illness and the coordination of those services;

The availability of psycho-social support services have certainly improved through the funding of non-government organisations. However the fixed term tender process means inconsistency in service provision and delivery across regions, inadequate collaboration, and poor marketing and coordination. If experienced GPs and health professionals are unsure of services in their own backyard, how can someone with a severe mental illness seek a clear pathway through a changing maze of disparate service options?

(e) mental health workforce issues, including:

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

Refer to b (iii)

(ii) workforce qualifications and training of psychologists, and

The Psychology Board of Australia and AHPRA have determined the benchmark for qualifications and training of psychologists. This is not uncommon in many professions these days. However, if experienced psychologists are still seeking to have their skills and experience assessed, improved and hopefully endorsed, post graduate training, placements and supervision should continue to be made available to allow additional bridging options.

(iii) workforce shortages;

There is significant ageing and severe workforce shortages in all disciplines within mental health. It is not attractive, underfunded and often complex and personally demanding work. It is rewarding however, but requires additional marketing to new graduates, better funding for post graduate courses, and a far greater number of paid clinical internships within both the public and private sector.

(f) the adequacy of mental health funding and services for disadvantaged groups, including:

- (i) culturally and linguistically diverse communities,
- (ii) Indigenous communities, and
- (iii) people with disabilities;

Other clinicians have great experience in these areas for appropriate comments, but if mental health is already so underfunded, how inadequate are services for those with additional complex and unique needs.

(g) the delivery of a national mental health commission; and

If the Commission could focus on service quality and effectiveness, improve service collaboration, and have the power to adequately respond to client and clinician service complaints, it will certainly be worth its weight.

(h) the impact of online services for people with a mental illness, with particular regard to those living in rural and remote locations and other hard to reach groups; and

Online services, leading to access to e-therapy from trained psychologists will better address the shortage of quality face to face therapy in remote regions of South Australia. This is but one strategy. We need to encourage more clinicians to live, work and/or travel to underserved rural and remote areas. New Medicare item numbers, incentive payments, travel payments, paid professional development, relocation expenses, funded tele-psychology equipment, funded post-graduate training places, locum opportunities etc, along with greater recognition and support for those clinicians currently servicing rural and remote areas would be greatly appreciated.

(j) any other related matter.

The profession of psychology is made up of quality professionals who truly care for the needs of their clients and feel privileged to work in this profession. The small yet loud self serving individuals who have denigrated others in the past few weeks should be ashamed, and do not reflect the views of the majority of psychologists who have embraced new standards and regulations, and who continue to advanced their skills and experience to ensure their clients receive the best possible service.

If you wish to discuss this further please contact me on .

Yours sincerely,

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