

Submission to Committee for Commonwealth Funding and Administration of Mental Health Services.

As a Clinical Psychologist with over 25 years of experience working in private practice with children with mental health disorders, I am writing to express my opinion about two particular terms of reference in the current enquiry into the Commonwealth Funding and Administration of Mental Health Services.

Clinical Psychologists have a significant role to play in the delivery of Mental Health Services in this country. Clinical Psychology is the only profession, apart from Psychiatry, whose entire accredited and integrated postgraduate training is specifically in the field of lifespan and advanced evidence-based psychopathology, assessment, diagnosis, case formulation, and therapy, across the full range of severity and complexity of mental health issues. We are well represented in NH&MRC Panels, other mental health research bodies and within mental health clinical leadership positions.

I would like to comment on Terms of Reference:

(e) mental health workforce issues, including:

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

(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;

Clinical psychologists assess, diagnose, predict, prevent, and treat psychopathology, mental disorders and other individual or group problems to improve behaviour adjustment, adaptation, personal effectiveness and satisfaction. What distinguishes Clinical Psychology from generalist psychology is the breadth of problems addressed, the wider range of populations served, and the broader and more individualised treatment options offered. For example, a generalist psychologist working as I do with children with mental health needs will offer only one treatment option, such as talking – based counselling. I will instead evaluate a range of treatment options based on evidence of their efficacy for each different population and then chose from a vast array of treatment methodologies, often offering several treatments concurrently. The need to offer such a range of treatment options reflects the complexities of the presenting mental health issues seen in my clients.

To give an example, I am currently working with a 13 year old boy diagnosed with Asperger's Disorder, which is a form of autism, and comorbid Obsessive Compulsive Disorder. He first saw a generalist psychologist for 4 sessions who taught him how to meditate and use deep breathing techniques. There is no evidence that deep breathing techniques will have any impact on severe obsessional behaviour. His obsession is with "damaging things precious to him". During the time of his sessions with the generalist psychologist, his obsession escalated: he commented to me that "meditating and deep breathing gave me time to think about my obsession more". At the time I first saw him, he had threatened several teachers at his school, was excluded, and was choosing to lock

himself in his laundry most of the day to keep himself safe, away from knives and other objects that he might use to harm objects and other people. Most recently he had killed the family cat and put his mobile phone in the microwave. He had hidden way knives in various places ready for the urges to take over him.

My multifaceted treatment approach has included assessment and conceptualisation of his obsessional behaviour; use of evidence based cognitive behaviour strategies to give him better self control of his obsessional urges; dynamic family therapy with his family of origin including his estranged father; introducing him to online treatment modules to give him daily practice at using cognitive behavioural skills and daily monitoring of his obsessional urges; counselling and referral to an adult Clinical Psychologist for his mother, who understandably is terribly anxious and afraid ;case discussion and advice given to the Psychiatrist who is now prescribing drugs to assist in managing his behaviour; advice to hospital staff when I recently arranged his admission to hospital for monitoring, after further threats of harm to himself and his mother; and liaison with school, police, hospital and ambulance staff to help them understand his mental health issues. After 10 sessions of individual therapy, we are starting to see some positive outcomes. This boy is now living back with his mother, has not harmed any objects or threatened any people dear to him for over two weeks now, and will be starting back at school soon on a modified program with a great deal of support which I have arranged from his school counsellor.

Several points I would like to draw from this case example:

- (1) Obsessive Compulsive Disorder is regarded as a mild or moderate Mental Health Disorder, which it is. However, the **impact** of this disorder for the many children I see is significant. It limits their participation in schooling, impacts detrimentally on their social relationships, and isolates them from the community. The same comments would apply to other disorders I treat every day of the week, such as depression, anxiety, and conduct disorders. I think it is vital that we think seriously about the impact of any changes in the Mental Health provision on these so-called mild disorders.
- (2) To effect any significant improvement in children like the one I described takes longer than 6 sessions. So far, I have had 10 sessions with him, and have also spent another 22 hours (unpaid) arranging community support and liaising with other professionals in his care. I would expect to see him for at least 4 more sessions to consolidate the therapeutic gains, and I will be involved with his school for at least 10 more hours (unpaid). He has lived with this disorder for over 4 years. He is very unlikely to require hospitalisation or police attendance again. I think we could argue for cost effectiveness here.
- (3) There are obvious significant gaps in mental health service provision for those in the community presenting with the most complex and severe presentations. But the needs of clients with so-called mild disorders who are so very impaired by their disorder needs to be taken into account. This is the unique specialised training of the Clinical Psychologist and, to undertake a comprehensive treatment of these individuals, more than twenty sessions per year are sometimes required.

- (4) The higher rebate I attract as a Clinical Psychologist recognises both the additional training and professional development I bring to my work, but also the untold hours that a Clinical Psychologist will spend in researching treatment options, writing reports and advice, and working collaboratively with other professionals, none of which is able to be claimed under the current Medicare provisions.
- (5) There is no doubt in my mind that if this boy had continued with the single faceted “treatment” offered by the generalist psychologist, relaxation therapy, both this boy and his mother would by now have come to grief. He has told both me and his psychiatrist that he no longer wished to live. He is now planning to go on a school camp. He enjoyed going to a party of a friend last weekend. He has just applied successfully for a job at his local McDonalds. He smiles every day. His mother is safe. They now have a new kitten. And I have treated 126 children like him so far this year.

Submitted with respect.

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