

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

Re: Committee of enquiry into the Commonwealth Funding and Administration of Mental Health Services.

I wish to comment on several areas within the frame of this inquiry:

- Workforce qualifications and training of psychologists
- The two-tiered medicare system
- The proposed reduction in allied health treatment session under the Government's 2011-12 Budget

Workforce qualifications and training of psychologists

I am a psychologist with a B.A with Honours in Psychology . I have been registered and working as a psychologist since 1981. I also have a Graduate Diploma in Mental Health (Infant). I am currently enrolled in the final semester of a Masters of Mental Health (Perinatal & Infant).

I have worked in the public sector for 30 years. For 21 of those years I have worked in Child and Youth Mental Health (CYMHS). I have been working part-time in private practice for the last three years. Prior to taking Maternity Leave I was a Team Leader in CYMHS.

I have seen a lot of changes since I graduated. When I was first at University I was one of a number of the students who argued for, and obtained the opportunity to undertake placements in the community during both third year and fourth year. Having gone to University straight from school I was keen to join the workforce and started my career in Cairns. I worked for Childrens Services and worked with juvenile justice and adoptive and foster parents and did crisis work with multi-problem families. After returning to Brisbane I worked as a psychologist at a residential for the assessment and treatment of children in state care. After this I became a psychologist in CYMHS.

When the goal posts changed and there was pressure to do a Masters in Clinical Psychology degree I investigated the courses on offer. I was dismayed to find that the local course included a whole semester of training in a very behavioural parenting program. This program was marketed very well as being evidence based. Significantly the government appropriately funded this program as part of the primary health sector not mental health. Unfortunately I was well aware that it didn't work in the low socioeconomic area in which I worked and certainly not with child protection clients. I was not prepared to invest my precious time or money on a program that had no evidence base for the population with

whom I worked. I also did not want to spend time or money on a course that considered CBT to be the answer to all psychological issues and that methods that worked with adults could be extrapolated to children. While working fulltime I supervised psychology students who appreciated the learning and experience they acquired while working on placement.

When I returned from maternity leave I only worked part-time and did not have time to supervise students.

Once my children were older, I finally decided to pay for a Master's degree in Infant and Perinatal Mental Health because I thought early intervention might prevent some of the heartache I saw. So many parents have described a history of postnatal depression (usually untreated) and unresolved trauma histories and children whom they considered difficult as babies. I paid for this course knowing that the APS and APHRA will attach no value to it because it is run by a psychiatry department rather than a psychology department. It embarrasses me that I have been paying annual fees to my own professional society to enable them to publicly devalue my experience and considerable ongoing learning. I know my clients and colleagues are benefitting from my increased learning in my chosen area of specialization.

A lot of research on attachment, infant mental health and brain development occurred after I'd finished my original degree. When I enrolled, I knew I was paying for a course where I would be learning something new and very applicable across the lifespan. Interestingly, Australian university Psychology departments have been very slow to recognise and offer even guest lectures on attachment theory or research. Most Clinical Psychologists are surprised to hear about Infant Mental Health. And many Psychologists endorsed as Developmental Psychologists have only learnt about development from the age of two. Few have learnt about how to recognise or intervene with infants who have been traumatized (by abuse, neglect or witnessing domestic violence). Of course you have to work with and support the parents.

I have been very surprised by the assertion by some Clinical Psychology Graduates that

Other than Psychiatry, Clinical Psychology is the only other mental health profession whose complete post-graduate training is in the area of mental health.

This is simply not true. There are many Masters of Mental Health courses available throughout Australia. You'll find most in the Psychiatry Departments. I have already mentioned the Masters of Mental Health course in which I am enrolled. Within Master of Mental Health courses, mental health clinicians from a range of professions can choose to specialize in Psychotherapy, Art Therapy, Play Therapy and Family Therapy. There are also additional professions who work in mental health such as Music Therapists and Dance Therapists. And of course, The Masters of Counselling Psychology equips psychologists to work in mental health. A lot of Counselling psychologists have expertise in couples work. Many clients with mental health issues commonly experience difficulty in relationships. In 2011, counsellors in virtually all settings (including forensic work) work with clients with a trauma history.

I think the complexity of client presentations now occurring benefit from this variety of expertise. The creative therapies are preferred options when working with traumatised

children and non English speaking multicultural clients- especially traumatised refugees. Young children invariably communicate through their behaviour and play.

I remember hearing one Clinical Psychology graduate proclaim that a sexually abused child “was not mental health but welfare”. He was slow to recognise trauma symptoms in children and the mental health trajectory for abused children. A bit more experience in the workforce would have alerted him to the number of welfare clients with mental health problems which are further compromised by unemployment and poverty, and the number of adults with mental health and substance use diagnoses that have a history of childhood abuse, neglect, and trauma.

I am very surprised by the submissions from some Clinical Psychologists. All Masters degrees cost money. Professional development workshops cost money. In my working career spanning 30 years I have spent thousands of dollars on professional development. When I chose my career as a psychologist I did not have any illusions about being well paid.

I didn't stop supervision after my prerequisite two years. I have had professional supervision for all of my 30 years of practice- not because I'm a slow learner, but because it is an important part of ethical practice and an important component of self care when working with traumatised clients for many years. And I haven't had to restrict my supervision to my own discipline. I have also benefitted from supervision with Psychiatrists, Social workers and Family Therapists. I am lucky to have worked in a multidisciplinary team of Psychologists, Psychiatrists, Social Workers, Occupational Therapists, Speech Pathologists and Mental Health Nurses for all of my twenty one years in the public mental health sector. My team has included an Indigenous worker and a Vietnamese worker. Our team has always been multicultural.

I am also lucky to count some Clinical Psychologists as colleagues and friends. Most do not retain the idea that their university training makes them superior to other mental health clinicians. And some have been gracious enough to acknowledge their learning from their “generalist” colleagues particularly in the area of child and infant mental health and I have benefitted from their access to updated interventions.

I don't think there are many people in the community who believe that “all they need to learn, they learn at university” (no matter what the profession). Life experience and work experience is usually valued. I believe that most psychologists working in the community are acutely aware that there is often a huge lag between practice wisdom and the ability of researchers to validate the wisdom with empirical evidence. Some of those Clinical Psychologists who have highlighted the extra hours spent doing a thesis and mastering additional research skills, fail to acknowledge that just because someone has expertise in research (including a PhD) does not necessarily mean that they make better therapists. I have not seen any research to suggest that the two are correlated.

There *is* research on the importance of the therapeutic relationship in facilitating client change.

The two-tiered medicare system

. The two-tiered system does not prioritize the needs of the public and should be abolished. All clients of medicare-rebated psychologists should receive the same medicare rebate. The distinction has been arbitrary and ill-informed and has become very divisive of the profession.

The Department of Health and Ageing commissioned an independent and wide-reaching evaluation of the Better Access program, overseen by experts in the research and mental health fields, which began in January 2009 and was completed at the end of 2010.

The research was conducted by Melbourne University and shows that in reality, there are no differences between types of psychologists, ie. both 'generalist' and 'clinical' psychologists are working with equally afflicted clients; both types of psychologists are utilising the same approaches to helping their clients; and both types of psychologists are obtaining very positive outcomes.

I believe the Better Access program has been a great initiative. I still work part-time in the public mental health sector in infant, child and adolescent mental health. Over time our expensive multi-disciplinary team approach has become more and more of a tertiary service. This means we see the most severe and complex presentations. Most have co-morbid conditions and require outreach to schools or homevisiting and constant liaison with other agencies. Since the advent of the Better Outcomes initiative we have an affordable, convenient and local option for those clients who are functioning well enough and feel safe to commit to individual therapy and who can benefit from short-term work. Accessible, timely intervention at the first presentation of distress is preferable to having a moderate presentation deteriorate because the public system had a waiting list. As an example, those suicidal adolescents who have been judged as not an ongoing risk but who would benefit from some therapy can now be seen in the community leaving the public sector free to maintain timeslots to manage crisis assessments and to offer a more comprehensive multi-disciplinary service to those who require it. This means that those who require a tertiary service do not need to wait as long. Over time our tertiary service has focussed more and more on providing services to the identified client which (in CYMHS) has to be the child. Often the parent has their own mental health issues that we don't have the resources to address any more (unless of course the parent is an adolescent in which case we address pre-morbid, postnatal and infant mental health issues concurrently). Unfortunately if the parent's issues aren't resolved the child's/adolescent's issues are unlikely to resolve. Better access has provided an avenue for this adult work.

In my private practice I have bulk billed some clients who cannot manage the private system. Their lives are too chaotic to keep regular appointments and some don't have a tradition of phoning to cancel appointments. Many of these bulk billing clients need a lot more support to stabilize their living situation before they can benefit from psychotherapeutic work. As an example, we can't work on alleviating their anxiety if their accommodation is unsafe. My personal opinion is that those clients at the severe end of the spectrum should not be managed in the private sector. These clients end up costing the private clinician. When they don't turn up we still have to pay room hire etc and any time spent liaising with other agencies is not remunerated by Medicare. They need to be managed by a team of multiple disciplines who are paid for the time they liaise with other services etc. These clients should be the focus of the ATAPS scheme. However they need to be served by experienced clinicians not new graduates.

The Proposed Reduction in Psychology Sessions

I don't think any psychologist has argued that the number of sessions be reduced.

Some examples that need to be considered are clients who require interpreters. It takes much longer to conduct a session with interpreters.

Many clients with trauma histories take time to trust their therapist. They need to be supported in this. Many chronically traumatized and complex cases are not going to be treated in the short term. Spending additional funds to support longer term work will have many economic and emotional benefits for the clients, their families and society. Work with children often requires more sessions. Parents need to be included. Sometimes (eg in the case of Prep children being suspended from school) it is important to do a school visit as part of the assessment and case formulation. Currently this extra work is not remunerated.

I strongly support the current provision of psychology sessions (12 sessions and 18 in extremecircumstances) under the Better Access Initiative be maintained for all medicare-rebated psychologists.

Thank-you for the opportunity to voice my opinions and concerns.

Regards

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