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Submission to the

Senate Enquiry into Commonwealth Funding

and

Administration of Mental Health Services

I wish to address three issues:

- 1) The proposed budgetary cuts to the Better Access to Mental Health Program. The proposed cuts reduce the maximum number of individual psychology services, available to a client, from 18 sessions for clients with exceptional circumstances to 10 sessions per calendar year, for all consumers of mental health services with a GP Mental Health Treatment Plan, regardless of their circumstances.
- 2) The inequities included in the proposed Better Access Medicare Program
- 3) The proposal that the two-tiered system for provision of psychology services by Registered Psychologists and Clinical Psychologists be abolished.

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1. Proposed cuts to number of psychology sessions available to clients under the Better Access to Mental health Program

While the vast majority of clients are able to make significant improvements in their mental health status with fewer than 12 sessions, there are a number of clients with severe mood disorders and clients with co-morbid conditions who require more sessions. Further, it is counter-productive, and a waste of time and money already spent, to withdraw therapy before such conditions are fully treated and stabilised. Current cuts disadvantage the most vulnerable clients, who do not have the finances to pay for psychology services. I work in an area of low socio-economic status, and as I already bulk-bill my clients I am not able to reduce my costs further.

I currently see a maximum of 20 clients per week. In the past twelve months I would have asked doctors to approve more than 12 sessions for approximately 2% of my clients. In these cases, the additional sessions were necessary, due to exceptional circumstances.

Scenarios

A sole parent, mid-30's, with severe depression and social phobia, unable to socialize, has no friends and not even able to do the family shopping alone. Client relies on mother for company to do grocery shopping. Client was doing a Distant Education OTEN course to improve future employment prospects, when commencing therapy.

Goal of therapy was to manage depression and anxieties and improve social confidence sufficiently to be able to do shopping alone and gain employment. During the therapy period there was also a death in client's extended family exacerbating client's distress and necessitating exceptional circumstance sessions.

Therapeutic Plan involved: clinical assessment and identification of the client's specific anxiety-eliciting stimuli; treatment for depression, de-arousal techniques and systematic (very graduated and diverse) desensitization. Grief counselling was also needed following death in the family. Relapse Prevention and Maintenance strategies were also put in place. Such a treatment plan can be achieved with eighteen sessions, but not twelve.

The added benefit of eighteen sessions, is that the sessions can also span a year. Therapy might commence with weekly, or fortnightly, sessions and then extend to monthly and six-weekly sessions, before therapy cessation. I have only needed to bridge a new year on one occasion, but it served to see this person regain custody and effectively parent her children.

One client who I saw for 12 sessions was an ex-prisoner who had spent much of his/her life in detention, and was released with severe depression and co-morbid Social Phobia.

The benefits of the additional sessions to these three clients, and to society generally were definitely worth the financial outlay of 12 and more (up to 18) sessions, in a year. The clients were co-managed with the GP, who prescribed medication and conducted periodic reviews. One client is now able to go shopping alone and is job ready, one is successfully parenting her children (who will now not grow-up in foster care) and the other does voluntary work.

Many clients with severe non-psychotic mental health disorders need to be treated in mainstream domains rather than in State Mental Health Services. It can erode the confidence of many clients with severe non-psychotic mental health disorders to be treated alongside many clients who have been treated as inpatients for psychosis, in State Mental Health Settings. The necessary coupling of clients with **severe** mental health disorders with clients with **very severe and psychotic** mental health disorders has the capacity to damage the confidence and social identity of clients with very-treatable mental health disorders who are desperately trying to maintain their psychological and social equilibrium.

Funding for psychiatry services has been increased, but psychiatry and medication alone are insufficient to treat many people with severe mental health disorders. Psychotherapy, including cognitive behaviour therapy, is also necessary in order that consumers can make necessary psychological, cognitive and behavioural changes so that medication may eventually be withdrawn. (It is largely accepted that the long-term effectiveness of many mood enhancing drugs is largely unknown.)

Medication without behavioural change does not cure most mental health disorders

Recommendation:

I urge the committee to maintain the current level of funding for the Better Access to Mental Health Program. It is a valuable and effective program. **It seems pointless to disadvantage the most vulnerable members of our community when the use 10+ sessions has been the exception, rather than the norm. Clients who do not seek improvement will not attend even 10 sessions.**

Much of the good progress made in earlier sessions can be lost without the gains being consolidated , such as when additional sessions are needed but not available.

2.The Rationalisation of Allied Mental Health Services under Better Access Measures allows for some consumers to access 10 individual sessions PLUS 10 group sessions,. Others will only be able to access 10 individual sessions

Consumers with severe mental illness will be discriminated against if they live in locations where group sessions are not available. This is most likely to happen in rural locations where there are insufficient suitable candidates to comprise a treatment group. Consumers will thus be disadvantaged if there are no suitable group sessions available in their locality. The Better Access to Mental Health Services Program needs to be equitable for all Australians.

Recommendation

Additional individual psychology sessions be made available for consumers where group treatment sessions are not available.

3. Maintenance of Two-Tiered System for Registered Psychologists & Clinical Psychologists

It seems farcical that the current two-tiered system for the acknowledgement of the additional expertise of Clinical Psychologists would be abolished by the Australian Federal Government.

1) Unlike Registered Psychologists, Clinical Psychologists have completed Post-Graduate Study which specializes in training professionals to treat mental health disorders.

Accredited courses for Clinical Psychologists in Australia are comprised of a necessary:

- two-years of full-time (or part-time equivalent) accredited academic study which has been designed to train psychologists in clinical assessment and diagnosis of a broad range of mental health disorders and severity levels; and evidence based treatment formulation, delivery and outcome evaluation.
- 4 supervised clinical placements (1000 hrs) in Mental Health Setting, and
- Thesis on a Mental Health Topic.

This is followed by professional supervision in a mental health setting, by a Clinical psychologist.

Graduate & Honours Psychology Degrees address a broad spectrum of human behaviours. These degrees provide a valuable professional foundation upon which to build specializations, but they do not develop specialist skills. 1) Graduate Degrees do not necessarily involve a placement in a Mental Health setting. 2) Supervised post-graduate practice is not necessarily completed in a mental health setting; and 3) supervision for registration is not necessarily provided by a Clinical Psychologist, or even a psychologist with expertise in mental health disorders.

2) State Mental Health Services recognize the expertise of Clinical Psychologists.

State Mental Health Services prefer to only employ psychologists with a minimum of a Clinical Master's Degree. They also recognize the value added by a Clinical Psychologist in treating mental health disorders, and by remunerate them accordingly.

3) I worked as a registered psychologist for 10 years before commencing, and subsequently completing, a Master of Clinical Psychology Degree part-time, while I continued to work full-time as a Senior Psychologist in a community setting.

I know first-hand the qualitative difference that completing the Clinical Master's Degree and the additional Clinical Psychologist eligibility requirements, has made to the service that I am able to provide to clients with mental health disorders.

4) Meeting eligibility requirements to be a Clinical Psychologist is a huge financial and life investment. (minimum \$16,000 HECS; \$8,000+ for supervisor fees; 4000 hours in time) However, it is a commitment that Clinical Psychologists have made, (and Clinical Psychologists in training continue to make), to add value to the treatments they provide to people with mental health disorders. The notion that additional training and supervised training does not improve the quality of mental health services is a nonsense. I also suspect that every tertiary institution world-wide would argue against the notion that tertiary education and professional supervision and training does not make a qualitative difference in professionals.

5) Two-tiered systems are recognised across all professions. Formal training is generally accepted to be the discriminator of the tiers.

Two tiers are recognized across the many specialties within the medical profession. GPs do not purport to be psychiatrists

6) There are other examples of two-tiered payments within the Better Access Program. For instance, I note that there are also two tiers of payments for GPs who prepare Mental Health Treatment Plans for the Better Access Program. Once again the tiers are predicated on formal accredited training.

7) The specialization of Clinical Psychology is recognized across all first-world economies. To devalue and erode the status of Clinical Psychology in Australia would be a retrograde step, and would degrade Australia's international standing in this field.

Recommendation:

I urge the committee to continue to recognize the specialization of Clinical Psychology for the purpose of the Better Access to Mental Health Programme.

When I need bone surgery I see a specialist orthopaedic surgeon, not a GP. Similarly, I know I would want to be treated by a Clinical Psychologist if I needed to seek psychological (not medication alone) treatment for a mental health disorder. Unless the two-tier psychologist system is maintained by Medicare, within the Better Access Program, clients with most severe mental health disorders may not be able to access the services of a Clinical Psychologist