15/07/11

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

Dear Ms/Sir

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

I have become aware of Committee's deliberations, regarding the above matters, and wish to provide the following information /view.

1. Mental Health services in the Country:

I have been a Counselling Psychologist working in Coffs Harbour for the last 28 years. Prior to this I was a Government employed Psychologist for some seven years. When I arrived here, the Shire had a population of 17,000 people, which has now risen to about 70,000. Basically, we have the same level of service from our local hospital Mental Health Unit, now, that we had in 1983, because of failure of the Government to keep pace with the growth in the number of people in this area and the changing demographic of the area from a stable country town with an episodic increase in population due to tourists, to a large coastal city with an increasingly large number of disadvantaged and disordered people, who have come here for survival reasons in response to the cost of living in the cities or because they can't survive there emotionally.

Most of these people come with their own pre-existing and chronic mental illnesses which are made worse by the fact that there is little work here to occupy them. We have a high level of alcohol and drug abuse and domestic and family violence and, in response to the drug abuse, a large number of

people suffering from major mental disorders – bipolar disorder and schizophrenia.

Since the Medicare system has been applied to psychology services, supplied through the General Practitioners, these people are now being seen, where as, in the past, they were not able to access any treatment, for the reasons given above. I am sure that these facts probably apply across rural New South Wales and Australia equally.

Our area also has no resident Psychiatrist. We have to rely upon visiting Psychiatrists, from Sydney and elsewhere, who are here for 2 to 3 days per week / per month and who supply inpatient and outpatient service and advice to the Mental Health units – inpatient and community. In response to this, the Psychologists, here, have been required to assist the General Practitioners with assessment advice and advice with regard to treatment and appropriate medication prescription.

As indicated above, the majority of clients here suffer from long-term and chronic illnesses. Because of their difficult circumstances, often their children developed emotional problems early in their lives and also suffer from chronic disorders as well as developmental conditions including: ADHD, Asperger's Disorder, Autism Spectrum Disorders, Developmental Delay and language and learning problems. These difficulties are being managed by the Psychologists in the area in support of the General Practitioners.

I'm sure that no one understands the situation in the country, even in a large rural setting like Coffs Harbour which appears to be quite affluent and well supplied with services. The surrounding area of Coffs Harbour – the Nambucca and Bellingen Valleys to Grafton – has similar problems to Coffs Harbour, itself, and relies upon Coffs Harbour as the resource for these areas. There seems to be no plan to replace the services provided by Psychologists if, and/or when, the funding of Psychologists in the country is terminated in response to the advice given by experts which are city based. This looks like a disaster in the making to me.

Interestingly, most of the psychological services provided by Psychologists, in this area, are provided by non-Clinical Psychologists. Interestingly, Clinical Psychologists only arrived on the scene, here, to service clients, when Medicare was provided to psychology services. Long before these

Clinical Psychologists arrived, the services they are portraying now as specialist services, only within the expertise of Clinical Psychologists, were being provided by the existing non-Clinical Psychologists in the area. In spite of this, we were able to develop and provide, here, a pilot programme for the case management of ADHD children with multiple handicaps, which went Australia wide. This was possible because of the experience of the local non-Clinical Psychologists.

2. The special nature of Clinical Psychology and its training process:

Psychologists are trained in two ways, those who are designated as being non-Clinical Psychologists do a four-year degree, with honours in Psychology, followed by two years of internship. During internship they are trained in assessment, psychopathology, and therapy. During these two years, they work with clients and study, train and produce papers to increase their knowledge base and their practical therapy skills. At the end of these two years, these Psychologists can practice in the community and manage the vast range of disorders presented to them from the community, successfully.

All the universities that train Psychologists now focus upon the training of Psychologists (both Clinical and non-Clinical) in the therapy called Cognitive Behavioural Therapy (CBT). This has been around for some 50 years and has been taught to Psychologists, General Practitioners, Psychiatrists, Occupational Therapists, Social Workers, Psychiatric Nurses and Physiotherapists, to assist in the management of clients with emotional problems/mental disorders.

This technique is very lockstep in its logic and is very structured in the way it is provided to the clients. Basically, this technique suggests that all clients, with a given condition, and irrespective of the aetiology of the condition, will respond to the same technique, which will reliably produce a claimed 60% success rate. This is the technique which Clinical Psychologists now lay claim to as their Holy Grail and that which, they insist, makes them special and the **only people** able to provide effective therapy, using this technique.

Clinical Psychologists are trained with the same basic four-year honours degree in Psychology and this is followed by two years of university-based training with placements. During these two years of university training, they

have little exposure to community-based clients, or the wider community, as they focus upon hospital-based clients with major mental disorders. This training does then not fit them for community-based practice. Therefore, their special ability in assessment and diagnoses are basically related to hospital-based clientele.

It seems, then, that Clinical Psychologists' claims to be especially highly trained are only true with regard to their work in hospitals which few of them now work in. Observations of new Clinical Psychologists, in my area, indicate that they have not had experience in as many formal assessment techniques, in their training, as intern Psychologists who have been trained here and elsewhere in my community. This would suggest that even their claimed special expertise in regards to formal assessment is not sustained by practical experience.

It is obvious that Clinical Psychologists are trying to maximise their income given the fact that they are claiming their expertise as being exclusive to themselves. It is also strange that, at the same time, the number of training places for Clinical Psychologists has decreased by 30%. They would be aware of this number themselves. One would wonder why Clinical Psychologists are trying to exclude other Psychologists from working with clients when there will be a shortage of Psychologists overall. One would have to question their motives.

There are many other Specialist Psychologists who are not Clinical Psychologists – Counselling, Forensic, Neuropsychologists, Community, Educational and Organisational – all of whom undergo the same level of training that Clinical Psychologists do and all of whom have the same level of skill with regard to assessment and therapy. These Psychologists also have a wider view of assessment, aetiology and range of possible (and equally “evidence based”) interventions, than that seen as being practised by Clinical Psychologists. It is bizarre for Clinical Psychologists, then, to portray themselves as being the only Psychologists with the training required to manage clients successfully. This is more the case when one realises that there is no evidence that Clinical Psychologists produce better outcomes with, and for, their clients than other, **even non-specialist**, Psychologists do. This was established by WorkCover New South Wales in 2009/10 which resulted in a standard fee for **all** Psychologists, of $150 per hour.

3. Two-Tier Medicare system:

As indicated above, there is no justification for a two-tiered Medicare system because of the fact that there is no reliable or independent evidence, that I am aware of, that Clinical Psychologists can reliably produce better therapy outcomes than any other Psychologist.

The problem is, though, that the cost of Medicare has blown out of all proportion because of the **usage** of the system. It is obvious that the Government of the day did not recognise what the demand for Medicare services for psychology/mental disorders would be/is, in the wider community. There is no over-servicing here, rather there is an urgent need to treat those people who have been untreated for the last 30 years, and who have suffered for this, and who need to learn to manage, and to overcome, the effect upon them of their mental disorders. As we know, adults with mental disorders produce mental disorders in their families and children which affect, and limit them, and the community.

As indicated above, Clinical Psychologists only joined the community psychology area after the approval of Medicare-based Psychology services and the two-tiered system. Prior to that, they were ensconced in their higher paid jobs with hospitals. Very few worked in the community.

The Australian Psychological Society, many years ago, established that a fee of $200 per therapeutic hour would produce a reasonable income for a Psychologist (given the 70% cost versus gross fee received that everyone agrees is the reality of psychological practice) and allow them to maintain their training, provide effective and appropriate therapeutic spaces to work in, provide the appropriate technological and professional facilities needed to carry out their practice and provide them with the income to have superannuation at the end of their career.

Since the Medicare introduction, Psychologists' salaries have **gone down** in response to the loss of income produced by the Medicare system and the need to bulk bill. Most clients are very resistant to (and very often unable to) make a copayment above the Medicare bulk bill fee, with the result that Psychologists must work longer hours, now, to survive in the private sector. As the majority of Psychologists are now of a more mature age, and as there is little incentive for younger Psychologists (who have been unable to gain Clinical status because of the limitation of training places) to replace them and to work for such a low fee when there is no chance to gain a reasonable

income or the potential to develop a superannuation programme for their long-term survival post-retirement, there will be no one to provide Psychological services in the future. This is more the case when one considers that Psychologist are required under Registration guidelines to engage in 30 hours of training per year. How does one fund this training and maintain an income and survival with such a very low hourly fee?

Workforce assessment indicates that there will be a shortage of all Psychologists, in the future, because of a gap in training which occurred some years ago. The only way to ensure that this gap is closed is to increase the Medicare fee to, at least, $100 per hour, for **all** Psychologists, which would allow them to survive financially and be able to provide for themselves in the future, when they retire.

4. The proposed/ Possible Redirection of Funding away from Medicare-based psychology:

I understand that there is a push to switch funding from the adult population to youth. This is based on the mistaken assumption that young people are more amenable to change and recovery from mental disorders than adults or that if they are treated early, they will not develop psychopathology later. I don't know of any evidence to prove that either of these assumptions is true. Having worked with young people, for many years, it is obvious that they mostly tend to dismiss psychological interpretations of their situation and, even more so, dismiss psychological therapy as not being consistent with their view of the world and/or their aims, lifestyle or goals.

It is also true that adolescent brains are in state of flux as they move through adolescence to adulthood and as their brains change in response to the effect of maturation and hormonal changes. This problem of brain change tends to militate against effective therapy. As indicated above, the production (and maintenance) of healthy adults, who are capable of raising healthy children, should be more of a priority for funding to prevent the development of disorders in children caused by familial and lifestyle factors.

5. Restriction of the number of sessions:

The Medicare psychological therapy process was designed to address “chronic mental disorders”. By definition chronic means long standing. There is very little evidence that disorders that are chronic respond well to

short term therapy, in response to the fact that long term disorders produce – especially in the case of anxiety and depression – **unconscious** schemas (the target of CBT) which are then hard to access and resolve. Obviously, if the client can't recognise or identify what their schemas are, then the client cannot communicate the root cause of their problems to the Psychologist and then there is nothing that the Psychologist can use CBT to address.

Secondly, long term emotional problems/mental disorders often have genetic and/or familial underpinnings which means that a more holistic approach has to be taken. This is not possible in the 6 plus 4 sessions that are now being mooted as the new session allowance. All this does is make sure that the condition is never addressed successfully or is addressed poorly. Neither of these outcomes will produce good long term therapeutic gains. This then would be a waste of time and money. If it is worth doing, it is worth doing well.

I think that the standard set up that the Medicare process commenced with is still the most appropriate – 12 sessions in two groups of 6 with the GP as gatekeeper, with the possibility of a further 6 sessions for the intractable chronic cases.

6. Summation:

In my community, Medicare funded psychological services have made a major, and very positive, impact upon the experience of emotional distress and disorder. Families who would not have been able to access treatment for the adults or the children and family, have now been able to do so, with good outcomes in the short and long term. It would be a disaster for my community to be deprived of this set of services and to return them to the dark ages of pre-Medicare days when there were only two psychology practitioners in Coffs Harbour and limited access to the hospital system, which produced the avalanche of drug usage, suicide and young persons with schizophrenia which has characterised Coffs Harbour for many years.

Yours faithfully

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Counselling Psychologist.