

SENATE INQUIRY INTO THE COMMONWEALTH FUNDING AND ADMINISTRATION OF MENTAL HEALTH SERVICES

I offer the following personal submission for the consideration of the relevant senators in relation to the above Senate Inquiry with regard to the Terms of Reference listed below:

- (a) the Government's 2011-12 Budget changes relating to mental health;
- (b) changes to the Better Access Initiative, including:
- (iii) the impact of changes to the Medicare rebates and the two-tiered rebate structure for clinical assessment and preparation of a care plan by GPs, 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;
- (d) services available for people with severe mental illness and the coordination of those services;

- (e) mental health workforce issues, including:
 - (i) the two-tiered Medicare rebate system for psychologists,
 - (ii) workforce qualifications and training of psychologists, and

I am a registered psychologist of almost thirty years experience with subsequent training in many fields of relevant professional clinical development. In all I have had twelve years of full-time professional training, including an eight year training with the Australia and New Zealand Society of Jungian Analysts. The latter includes intense clinical training via seminars, supervision of casework and extensive clinical application seminars, theoretical and clinical writing and psychiatric diagnostics. Thus at the outset I want to stress that when I work professionally I am always engaged in *clinical psychology*, whether in short or long term analytic work, with children, adolescents or adults, individuals or couples. Yet, according to the dictates of the Australian Psychological Society which seems to be the advisory body of the Government's choice, because my *first* post-graduate training was a two-year Bachelor of Education in Counselling (which incidentally included many clinical components) I do not qualify for the classification "clinical psychologist" and accordingly am classified by the Medicare two-tiered system as an "Allied Health Worker" and rebated at the lower level of reimbursement. This situation, that is to say, that a senior clinician in working in "mental health" should be accorded the status of allied health worker is anomalous to an absurd degree, and made further so by the recent changes to the Medicare Better Access scheme which reduces the number of sessions from a possible eighteen to ten. I shall elaborate on this further below.

To emphasise the inadequacy of the APS-sanctioned notion of clinical psychology, and for brevity, I make use of the (also professionally sanctioned) Wikipedia definition of clinical psychology as: ..."an integration of science, theory and clinical knowledge for the purpose of understanding, preventing, and relieving psychologically-based distress or dysfunction and to promote subjective well-being and personal development". Further to such definition and standards set out by APS and numerous other bodies such as my own professional associations of ANZSJA and IAAP, I am also trained in and engage in psychological assessment. As a published author of professional papers both here and internationally, I have engaged in clinical research, teaching, consultation, and program development and administration. My work both in practice and in my professional research and writing, has over many years included supervision by and consultation with individuals in leading positions in psychiatry, psychoanalysis and clinical psychology in this country as well as in the U.S. and U.K. (Names and references available if required). Areas of interest which have led to such consultation include: Attachment and Affect Regulation theories; the neuroscience of infant development, the interface between neuroscience and psychoanalytic theories, with particular emphasis on contemporary relational psychoanalysis as developed in the New York Post Doctoral program and the work of the Boston Process Change

Study Group. The study of neuroscientific publications, as well as the association with affect regulation and attachment theories mentioned above, has included study of and consultation with researchers in the field of effective clinical practice of “mindfulness (Buddhist) theory” and the introduction of a strong element of such evidence based work into my clinical practice and teaching.

As a Jungian analyst with a strong interest in contemporary emergent theory and its clinical application, I have engaged in dialogue and vigorous exchange both online and in person at a number of international conferences where contemporary Jungian thought and clinical practice interfaces with all of the above areas and have written and/or lectured in most of them. I have lectured in our ANZSJA training programme on the importance of keeping abreast of neuroscientific research in order that our future analysts may be part of the growing inter-disciplinary exchanges which further all fields of mental health.

At the time of my initial registration with the Victorian Psychologists Association, in , I chose not to join the Australian Psychological Society as I felt that the considerable clinical aspects of my training in my post-graduate degree Bachelor of Education in Counselling and subsequent supervised placements would not be sufficiently recognised by that body. This was because the definition of “clinical” as mentioned above, seemed to reflect a particular emphasis in undergraduate training rather than the further experiential learning and nature of placements and supervision.¹ Therefore membership of the APS would be of no particular value to me. I have found this to be the case until the advent of the Medicare Better Access scheme, when the position the APS has taken politically has made clear the very real invalidation of what has been dedicated and demonstrably effective clinical work. I am sure I am not the only well-qualified psychologist to be disadvantaged in this way with the flow-on effect in terms of public access to depth psychotherapy increasing the societal disadvantage and ultimate public cost.

Among the short courses I have completed over the years as part of my professional development have been some focussed on cognitive behavioural therapy, which is the treatment mode favoured by the APS. While there is a place for the evidence-based effectiveness of CBT in my practice, to regard it as a mode *par excellence* is not soundly based. Of the solid evidence for the efficacy of long term psychotherapy which has been gathering over recent years, the work of Dr. Norman Doidge has been the most prominent and accessible to the general public and politicians alike, and it is to be hoped that the relevant government members are familiar with its findings. I believe these and other evidence-based findings are referenced in the submission from the Australasian Confederation of Psychoanalytic Psychotherapies of which ANZSJA, and therefore including myself, is a member.

In the light of the above I think it might be understood that I find it somewhat galling that my many years of intensive clinical training and extensive clinical experience are invalidated under the Medicare schemes, merely because I chose to pursue rigorous training and well supervised experience other than that deemed “clinical” psychology by a body which has in fact set itself up as arbiter of standards.

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In closing I want to give a brief account of the experience of working with one person, typical of many, under the Medicare scheme for which eighteen sessions, though not adequate for lasting changes, allowed the woman whom we shall call Anne (whose permission I have to tell her story) to get to a mental and emotional space where she could work part time to support her therapy. When Anne came to me she was unemployed, considered herself unemployable, occasionally suicidal and was living on a disability pension. She had been suffering from post traumatic stress related anxiety and depression for over twenty years and had experienced some short term relief from anti-depressants prescribed by a psychiatrist who could see her only for half an hour fortnightly. We commenced analytic psychotherapy once per week and after about six sessions I introduced Anne to the adjunctive “mindfulness meditation” breathing practice, which she has followed consistently since. During the last block of her eighteen sessions (which had been directed by her GP because the serious illness of her mother had worsened her condition such that suicidal ideation had returned), our work had proceeded to a stage where, as mentioned above, Anne was able to work two days per week and to resume studies in botanical science. Though still subject to reiterating negativity and depression, Anne continued her sessions with me at a reduced rate and now, approximately one year later, has finally been able to let go of the emotional hold of her traumatic history, has greatly improved relationships with family members and neighbours and has returned to work and study, each part time and both in her chosen field of botanical science. **It is most important to note that this situation would not have been possible at all without the eighteen sessions of the Better Access scheme and that it is a reflection in my practice alone of many other similar stories.** Other stories from my practice include many for whom psychotherapy would have seemed out of the question and for whom ten sessions of CBT alone would have been insufficient. These would include people suffering from PTSD and the personality disorders as well as those seeking more meaningful lives and employment. In fact, over the almost thirty years of my clinical work I would estimate that approximately one third of patients have had CBT elsewhere. Frequently such people report improvement in the short term but eventual regression to prior states. **From the clinical perspective of neuropsychology, my opinion is that this is because there has not been time for sufficient structural change to take place in the brain for the consolidation of the work.** At another level of analysis, the conscious emotional perspective, there has not been a sufficient relational basis to form an ongoing reference point for the patient to internalise as their own psychological strength. Many studies over the past three decades have pointed to the crucial role played by the therapeutic relationship itself, and while this cannot develop in ten sessions, its potential of promising beginnings being cut short can be counterproductive.

For the above reasons I would ask the relative Senate members to consider :

- a) ways in which psychologists whose clinical experience is extensive as is mine and who may not be and not wish to be, members of the APS could be accorded their rightful place in the Better Access scheme; and
- b) that the move to tenth sessions rather than eighteen be recognised for the retrograde and unhelpful step it will prove to be in the stated intention of Government to improve mental health in this country.