SUBMISSION TO SENATE REVIEW OF MENTAL HEALTH SERVICES

This submission provides background information and addresses the following terms of reference:

B4 – Impact of changes to number of allied health treatment services for people with mild and moderate illness

D – Services for people with severe mental illness and coordination of these services

E1 – Impact of two-tiered Medicare rebate for psychological services

Background

I am writing in my capacity as a clinical psychologist in private practice who has been a member of the Clinical College of the Australian Psychological Society for over 30 years. Having trained as a clinical psychologist I have completed additional training as a family therapist in Canada. I have worked in both the public sector with children, adolescents and families and in a mental health service, hospital and community health centre and in private practice since 1986 as both teacher and clinician. My clinical practice is spread across a Complex Needs Clinic which sees clients with multiple and difficult presenting problem and circumstances and a traditional private practice. I have also practiced before and after the Medicare rebate was introduced. These experiences allow me to compare and contrast across service delivery modes and when different funding arrangements applied.

Impact of changes to number of allied health treatment services for people with mild and moderate illness

While it may appear that reducing the number of available sessions per annum and removing the possibility of up to 18 sessions per calendar year would have little impact on clients, this is not so. In our private practice many clients do resolve their difficulties within 6 to 10 sessions. However there are a significant, if smaller, number of clients who require additional sessions. These are most often people seen in our Complex Needs Clinic who are struggling with a range of issues including intellectual disability, autism spectrum disorder, serious and life-long health issues like multiple sclerosis, refugee status, poverty and drug and alcohol problems. As we primarily see families it is often children and adolescents who present as clients with difficulties so extreme they can no longer be accommodated in schools, are actively self harming and suicidal or abusing drugs and alcohol. Such matters require the involvement of the total world of the young person and their family and resolve with co-operation and intense involvement in the early stages of therapy. It is not uncommon for such clients to be seen for a full 12 to 18 sessions in the first year and then decrease to monthly or bi-monthly in the next two years. Success with these matters may mean the child is not removed to foster care, is not abused or requires specialist schooling. Each of these outcomes puts a significant impost on the public purse in both the short and long term as it is clear from the research that matters unresolved in childhood can become significant and debilitating adult issues. It is also clear that family therapy approaches which harness the resources of the person's whole social network are effective in the resolution of both child and adult difficulties (Carr, A. 2009)

A second vulnerable and expanding group are families experiencing marital breakdown. Where a separation is acrimonious and lengthy court battles ensue, children are often vulnerable to develop a range of anxiety and stress symptoms. Such matters rarely resolve quickly and it is important that both children and families be supported towards a healthy outcome.
It is recommended that 18 sessions of therapy be available to clients who needs are complex when therapy is provided by a clinical psychologist or other accredited psychologist. It is also suggested that a process be developed to overview additional sessions by psychologists, in order to ensure they are cost-effectiveness.

D – Services for people with severe mental illness and coordination of these services
Patients with a severe mental illness are best supported in their families whose assistance can be central to a patients well being and time out of hospital. A single venue where such vulnerable clients become known and their families also provided with support and guidance is highly effective.
Our practice includes a psychiatrist who can diagnose and medicate clients who may initially see a psychologist. The client and their family can then return to the referring psychologist to address family and relationship issues. This has proved an excellent model that reduces stress on already stressed families and allows for the best co-ordinated care and has been highly valuable with severe depression, suicide and self-harm.

It is recommended that cost-effectiveness analyses be conducted to compare services such as the one described.

E1 – Impact of two-tiered Medicare rebate for psychological services
Currently there is a two tiered system for generalist psychologists and clinical psychologists. The latter are eligible for membership of the Australian Psychological Society and have successfully completed a Masters or higher qualification, specifically addressing complex clinical matters. While it is reasonable to suggest psychologists can attain this level of skill through practice and ongoing professional development it would be important that this be verified through a formal accreditation process.
Referring medical practitioners could be entrusted to refer more complex matters to clinical psychologists and those who pass an assessment of higher competence.

It is recommended that the two tiered system be retained and doctors ascertain the level of complexity and hence level of expertise required to address the case and refer accordingly

It is recommended that a mechanism be developed to accredit generalist psychologist to accept referrals of complex matters.

Carr, A. (2009) The effectiveness of family therapy and systemic interventions for adult-focused problems Journal of Family Therapy 31: 46–74

Carr, A. (2009) The effectiveness of family therapy and systemic interventions for child-focused problems Journal of Family Therapy 31: 3–45