

Senate Community Affairs Committee - Commonwealth Funding and Administration of Mental Health Services

I respectfully wish to make a submission regarding the Government's funding and administration of mental health services in Australia, with reference to the proposed changes to the Better Access. I am responding to : (e) i - the two-tiered rebate system

(d) iv - the impact of the number of treatment services.

(e) mental health workforce issues:

(i) the two-tiered Medicare rebate system for psychologists

I am a clinical psychologist in private practice which means I see a wide range of people with diverse presenting problems and who have different levels of intellectual capability, self-awareness and internal stability. I undertook my psychology studies as a mature age student and after completing my Psychology degree and Honours year, I worked for a year as an intern psychologist. During that time I realised how many gaps there were in my training so I returned to university to do the Master of Clinical Psychology. I believe the advanced training and practice has been essential to do full justice to the clients I treat. The undergraduate psychology degree had relatively few units focussed on counselling and psycho-therapy. It did not cover indepth training on the mind / brain with regard to mental health disorders including organic brain disorders, nor specific therapy for different populations such as adults versus children, individuals versus families, nor the extensive range of presenting mental health disorders. There was also no supervised practise to ensure that both the psychologist and the clients they were treating were fully supported. This is understandable as it is a broad degree training people to work in human resources, audiology, organisational and industrial settings, and educational and developmental settings.

I am increasingly being referred clients with more complex disorders including severe long-standing trauma, often from multiple forms of damaging childhood abuse. Many of these clients were previously hospitalised, medicated, have made suicide attempts, and seen various psychologists and psychiatrists, but their difficulties remained. My Masters training provided me with a much broader perspective on mental disorders and techniques to enable clients to achieve lasting change. For example having greater knowledge the contributory influence of organic brain symptoms, detecting signs of psychosis such as schizophrenia, thyroid implication in depressive symptoms, bipolar symptoms in severe depression and the complex and fragile development of the psyche (our sense of our self) in early years. The additional training also prepared me to face the trauma, rage, horrific stories of abuse and suicidal desperation that is my everyday work. I sincerely hope that the two-tier level remains in place to encourage psychologists to undertake the additional training and to increase the likelihood that clients will receive the quality treatment they need.

I have seen many clients who were misdiagnosed or were treated with no positive effect. If clients do not receive treatment that works, some lose hope and from there it can be a short step to tragic consequences. I have been told by some doctors and clients that some psychologists won't treat clients with the more complex disorders including Obsessive Complex Disorder, Dissociative Identity Disorder (formerly called Multiple Personality Disorder), severe childhood trauma or personality disorders. Most of my work is with these clients with complex conditions. I strongly believe that my Masters training, plus the ongoing training I undertake, equipped me for this.

(b) changes to the Better Access Initiative, including:

(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;

The current allowance of a maximum of 18 sessions is desperately needed by many who seek psychological services.

I most often treat clients with complex psychopathology though I also treat clients with mild to moderate psychological distress. I understand that there is a perception that psychiatrists see the more complex clients whereas psychologists see the mild to moderate clients. From my experience and that of some of my colleagues, this is not the case. I was interested to discover that psychiatrists choose to practice in one of three ways: some provide medication and do not provide psychotherapy (I think this is quite common) ; others only do psychotherapy (I understand this to be the minority), and others both prescribe medication and provide psychotherapy. Research supports the long-lasting effects of therapy and also supports combined treatment with therapy and medication for specific disorders. There is less support for medication only for many psychological disorders.

If clients have had a reasonably supportive upbringing with minimal neglect, or physical, emotional or spiritual abuse, and no sexual abuse, they are more likely to have developed a stable sense of self, have self-confidence and a sense that they are valued. They are likely to have healthy coping strategies, can function well in everyday living and can build supportive relationships with others. Such clients usually only seek therapy if they have experienced an event out of the ordinary. This may be physical or sexual assault, a serious motor vehicle or other accident, major trauma such as fire or flood, or other harmful events such as workplace bullying, financial reversal or the unexpected loss of a child or partner. When such a major and unexpected event occurs, even resilient individuals may feel overwhelmed and unable to manage. Their coping strategies may be temporarily disabled and they may experience depression, post-traumatic stress disorder or panic disorders, etc. For these clients it can take from 4 to 12 sessions (or more), depending on the intensity of the stressor, to re-establish former coping strategies. It takes time for an individual to adjust to the reality that traumatic events can occur unpredictably and are out of their control. The treatment may take relatively few sessions because the individuals can re-establish their original resilient and stable psychological structures.

There is a marked difference between clients with stable backgrounds and those who have experienced severe neglect or any of the forms of abuse in their childhood or teenage years. In these cases the individuals may not have a stable sense of self. Their reality testing may not be intact. They probably cannot assert themselves or say no. They may not be aware they have the right to do so. They may not be able to set limits on others or be clear about what is their personal experience versus the experience of another (impaired boundaries). They are more likely to have a fractured sense of self and so can behave quite differently at times. They often cannot regulate their emotions and can be buffeted by emotional swings from anger, to terror or to hopeless despair. They often hate themselves and self-mutilate or attempt suicide. These individuals develop coping strategies which are usually unhealthy because there was no way to be healthy in their childhood environment; the family environment was too destructive. However these coping strategies may hold back the worst of their distress until a major stressor occurs. This can be any of the unexpected

events as mentioned before or it can be having a child and suddenly remembering the abuse they suffered when they were a child. Or being in a relationship that becomes violent. Sadly these individuals are more likely to be in relationships which are controlling or have domestic violence. Some of these individuals cope using additions in any of the forms available: drugs, sex, gambling, shopping, eating, etc.

The earlier in life the neglect or abuse occurs, the more severe the insult to the mind and emotional structures which are being developed. I hear life histories of such deprivation, depravity, cruelty and neglect that I have the greatest admiration that these people somehow survived and are managing as best they can. I believe you would know of how severe and wide-spread childhood abuse is; the usual statistic just for sexual abuse of minors is 1 in 3 females and 1 in 5 males. In my clinic, it is closer to 2 out of 3 females. Unfortunately the most insidious, toxic and long-lasting form of abuse is emotional abuse, the one that leaves no visible scars. Destructive childhood circumstances occur at all socio-economic levels and the ramifications for the individuals, their families, mental health services and society are very high.

People who have experienced trauma and abuse in early life require extensive psychotherapy to first build a foundation for a clear sense of self, and to learn that they are worthwhile (not worthless, stupid, will never amount to anything, unwanted, waste of space, disgusting, hateful, etc as they were repeatedly told). The level of fear, rejection, humiliation and guilt at deep gut level can be very high. It can be very difficult for these clients to allow themselves to experience this psychological pain so they can work through and resolve the trauma and regain a sense of worth. A limited number of therapy sessions may require the therapist to put a psychological band-aid over a deep septic wound without first destroying the underlying cause. If the wound heals from the inside out, lasting healing will result. Hence the high number of people that continue to seek help for the same problem or harm themselves or others.

The Better Access system has been an inspired and precious boon to those urgently in need and the statistics have shown very positive outcomes. The current limit of 18 sessions per year for these complex clients can be difficult to manage depending on when during the year they first attend. I work with them to space out sessions to balance the effectiveness of treatment, to keep them stable and safe and to ensure that there won't suddenly be a lengthy gap. As clients dismantle unhealthy coping and develop resilient and healthy coping, they are vulnerable and need careful management. It takes some time for the new coping strategies to become a firm part of their psychological make-up.

I wonder if you would reflect for a moment on the length of time you have needed in the past to resolve a deep-seated trauma or to change a life-long pattern at the level of your conscious and unconscious thoughts and beliefs, as well as in your emotional reactions and your behavioural responses.

18 hours is less than one day.

I make a plea on behalf of my clients that the number of psychological sessions is not reduced from 18 to 10 in a calendar year.