Senate Community Affairs Reference Committee Inquiry into Commonwealth Funding and Administration of Mental Health Services

My submission will address two areas of concern (i) the government's plan to reduce the number of Medicare-funded sessions under the Better Access Initiative and ii) the Government's inquiry into the two-tier system of psychologists separating Clinical Psychologists as specialised services. I would also like to make some further points with regards to related matter.

The number of Medicare funded sessions

I think it is very disappointing that there has been a move to reduce the number of sessions. Many of my colleagues will have noted the fact that many treatments for moderate to serious issues take about 12 – 18 sessions. You will also know that the average number of session used by clients in the scheme were only on average four. I think it is evidence of the fact that psychologists or clients are not rorting the system. In my experience, clients often get better quickly but some take a longer time. Doesn't the smaller number of average sessions indicate that the scheme is working by only using what is required for everyone to improve? Doesn't it demonstrate the integrity of psychologists not to drag out treatment if enough change has occurred for clients to improve in fewer sessions? I have had many clients over the years require 12 sessions because of severe issues. Why are people with serious issues going to be punished because many in the system have improved more rapidly than would be expected?

The two tier system

It is a shame that my profession has been so divided on this issue. My main concern is that many of the psychology professions other than Clinical Psychology are not committed to undertaking only proven treatments. While the other Colleges and 4+2 year trained people could be doing proven treatments such as Cognitive Behavioural Therapy (CBT), they don't have to and many are very vocal at Mental Health Professionals meetings on their negative thoughts about proven treatments such as CBT. My massage therapist might be able to diagnose my back issue correctly, but that doesn't mean I should get Medicare rebate for her skills and she should insist she be treated like a doctor.

The government would be getting better value for their money by paying more to the sorts of psychologists who have actively chosen a Masters course that only uses proven treatments. More importantly the government, by their two-tier policy is actively encouraging more psychologists to study proven treatments. I fear if we go to a one-tier system this important distinction will go and it will give the message that all therapies, regardless of how ineffective, are equal.

Related matter and final point

Firstly I would like to point out that as a Clinical Psychologist in private practice before and after the Better Access program, I believe the Program has been a success in providing impetus and financial support to receive warranted psychological support. I believe it is generally being managed well by GPs needing to make the referrals. I have seen many clients who normally would

have not been able to afford therapy to be able to have a number of treatment sessions and make significant gains and achieve good mental health. I like the way it has improved communication with GPs and that we are all working together for good mental health in our clients.
I would like to take the opportunity; however, to address some of the concerns I have about the Better Access scheme or people's comments about it.

There has been some criticism that people who could afford psychology as opposed to disadvantaged groups are using Better Access. I believe that there are still some services lacking for these disadvantaged groups, but I would urge the government not to take funding from the scheme in general or means test the scheme to make up this shortfall. To get a MHCP a person has to demonstrate low functioning. The impact of poor mental health on all people is stressful and a Medicare rebate not only makes it more affordable, but also makes the GP more likely to suggest psychological treatment to the patient, and makes the patient more likely to attend if it is endorsed, so to speak, by the government rebate. People who work hard and are successful are just as likely to get mental health issues and the impact on the economy of poor mental health on people in higher socio-economic status is important. In my years of practice I have successfully treated doctors, lawyers, teachers and other formerly high functioning people who have been unable to work due to depression, anxiety or family issues. To say these people who contribute so much to the economy don't deserve government assistance to get their issues resolved through proven means is simply not good social or economic policy and not truly equal.

My other issue with the Better Access programs is when treating young children for behaviour issues or mental health problems. As I am a former teacher and clinical psychologist, I get referred a lot of child cases. Many of the child issues such as anxiety or behavioural issues are inadvertently encouraged by poor parenting practices and so I have to teach the parents better parenting in Cognitive Behavioural Programs such as Triple P – Positive Parenting Program. The way it currently stands, the person who has the issues receives the Mental Health Care Plan (MHCP) and then that person has to be physically in the room for sessions. While this is appropriate for adult clients, when it is a 5-year-old child who is demonstrating problem behaviour it does make it tricky. Of course to treat such a young child, a clinician has to treat the parents, but the current system makes it difficult. Either the parents have to get a MHCP (warranted in many cases because their own mental health issues are impacting on their child or the child's issues are impacting on their well-being) or the child receives it and then physically has to be in the room – even though we will be discussing better ways to manage their behaviour. Obviously parents can become very defensive about perceived flaws in their parenting, so to ask them to get a mental health plan has them taking offense and then not attempting to get much warranted treatment. I would urge the committee to consider some sort of clause where the parents of the child with a MHCP can see a clinician by themselves to treat the issue. This is not to say children won't be part of the therapeutic process – but it will make it much easier for parents to access much warranted treatment. (I would suggest children under 12 would be an ideal age where we can see the parent).

I would also like to address the school chaplain issue. I am very concerned that the government has stayed committed to provide funding to such a service. Recently there was a job advertised at a local school for a school chaplain for female students. When I called to enquire about the position and what it entailed, the person told me that the position was for female students to talk about female sorts of concerns such as self-harm. They then told me that the only qualification that is currently needed by this role is a Diploma of Youth Work. This person then went on to say that the job of chaplain is to refer on in tricky cases – but what is the point of having someone who is there to provide assistance but can't actually provide assistance and needs to refer on? How on earth can the government justify funding for poorly qualified people like this to be dealing with this work? For the same amount of money as a school chaplain is paid a year ($30,000), the government could be paying a clinical psychologist to treat clients with proven treatments for 252 sessions – providing an opportunity to improve their well-being. I also see in the job description chaplains can provide parent training – again, what is their experience here and why get a poorly qualified person to do such important work.

Unfortunately mental health often attracts people who have good intentions and are often very good at building rapport, but ultimately don't have the skills to treat people with proven treatments. There is, of course, in Australia, always an important role for a word of cheer and a kind heart, but we should not rely on good intentions as being enough qualifications to make a genuine change in the mental health of Australians. Over the last 50 years psychology has evolved to include the sorts of training that ensures there is a high likelihood of positive change, with the ultimate course being a degree in clinical psychology that only teaches proven treatments. I have respect for all psychologists, but at some point we have to acknowledge that unless a person has committed to a course that equips them to treat all cases regardless of seriousness in a timely and effective manner, then we have to assume they are not doing the best job and thus should not be given equal standing in the important business of improving the life of many Australians.

Sincerely
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