5 August 2011

Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600
Australia

Dear Senators,

I am writing to you regarding the Funding & Administration of Mental Health Services Senate Inquiry. I, like many Australians, was thrilled to hear that the Gillard Government was providing more funds to Mental Health, during the last budget announcement. However, I was shocked and repulsed when I read the fine print! I felt conned.

I come from a family suffering from at least three-generations of bi-polar and depression. I currently work in the field of Mental Health, and am studying for my Masters in Public Health. To be blunt, the situation and solution regarding the problems in mental health and the limiting of services under Better Access is simple; but due to very large and powerful lobby groups, including the AMA and APS, the clear pathway to beneficial mental health has become obscured. I recently read what one Senator responded to their constituent's letter:

> The recent Better Access evaluation shows that nearly 72 per cent of people who received an allied mental health service after a GP Mental Health Treatment Plan received between one and six services

If that statistic is true, what was the reason for this statistic? You have to wonder why they only went for 1-6 sessions. Was it that they had great treatment and were cured after only 1 session? Perhaps it was a problem that needed referring on to another agency to help with issues such as grief. Was it that they still were in need of therapy but weren't ready to commit to the process? Was it that their GP, who is not an expert in mental health, incorrectly recommended them to therapy? Or was it that they went to an untrained clinician in the field of mental health and should have gone to the one fully trained in a clinical environment and uses evidence based best practices, the Clinical Psychologist. That statistic should not be a reason to cut the benefits, as it's inconclusive as to the reasoning behind their minimal usage of the services.

This same senator was spot on this time when she wrote:

> Those people who currently receive more than 10 allied mental health services under Better Access are likely to be patients with more complex needs...

However, she failed in her conclusion to the problem:

> ...and would be better suited for referral to more appropriate mental health services It is important that people get the right care for their needs.
>
> People who need over 10 sessions of allied mental health services a year will still receive care through a range of other services including:
>
> - Medicare Benefits Schedule consultant psychiatry items;
> - Flexible Care Packages; and
> - State mental health services.

I know many Clinical Psychologists (*i.e.* MAClinPsych, or PhDClinPsych) who have left working for community health based mental health teams, purely for the reason of too much bureaucracy. Their time was inefficiently used; they saw approximately 3-4 patients a day, whereas they could see up to 6 or 7 per day in private practice. For those clinical psychologists, their motive was about helping those suffering from mental health problems. On the other hand, a recent psychologist who just graduated from university has seen the golden carrot of working in private practice. A recent graduate with no experience in a clinical setting can provide therapeutic 'help' without any past work in the field, under the MBS system (*e.g.* via Better Access, ATAPS, Flexible Care Packages etc). Many counsellors and Psychologists do excellent work, but they do lack the experience and evidence based skills required to treat many mental health problems and especially complex problems.

Furthermore, this senator stated that these people in need of over 10 sessions would be treated by "consultant psychiatry items", as one of the three options. Please look into this to see how psychiatry is saving the Australian taxpayer money. What are the on costs associated with prescribing medication (that is what Psychiatrists do), plus there is the knowledge that they are often (in larger cities especially) treating the worried well. They have no capping at the number of sessions, and their fees are by far in excess of what a Clinical Psychologist gets under the MBS. What is the amount of money spent on subsidising anti-depressants, ADHD medication, anti-psychotic medications etc? Sometimes they are necessary, but a Clinical Psychologist treating those with complex disorders will try to move a patient on from the medications prescribed, to changing their behaviours, their way of thinking, their lifestyle, (as according the Ottawa Charter and the philosophies behind the new model of public health).

Back to the point this senator made:

> People who need over 10 sessions of allied mental health services a year will still receive care through a range of other services including:
>
> - Medicare Benefits Schedule consultant psychiatry items;
> - Flexible Care Packages; and
> - State mental health services.

Please tell me how these people will 'receive care' from the Flexible Care Packages (run by the Medicare Locals) who employ counsellors, some psychologists, but very few Clinical Psychologists (the Medicare Locals have a 1-tier system, paying both counsellors and Clinical Psychologists the same, thus few Clinical Psychologists would work in that environment and support the discrepancies of services being provided). How will a fresh out of Uni counsellor or Psychologist employed by the Medicare Locals with little to no experience in a clinical

setting ever hope to help those with the extreme mental health disorders which requires an in depth level of knowledge on how to provide evidence based therapeutic interventions.

The state mental health services have already experienced and exodus from those who have opted out of wasting their time filling in paperwork for the government and the other bureaucratic red tape so either went into private practice or opted out from mental health all together and went into Management!

So, Senators, I put it to you, to think about the following scenario. Think of either yourself, or someone you care about deeply who suffers from chronic depression (*e.g*. your partner, your child) – we'll call him "Joe". Imagine that Joe's depression is complicated by an exceptional circumstance, he has suffered severe trauma: During a bushwalk in early January, Joe's best friend is critically injured and dies in Joe's arms. Despite no crime being involved, Joe felt responsible for his friend's death. Joe needs help, desperate help to overcome the problem:

> In Australia, each year there are approximately 2000 suicides!
> http://www.livingisforeveryone.com.au/IgnitionSuite/uploads/docs/LIFE-Fact%20sheet%203.pdf

Joe is already in therapy. Previously, Joe had been going to a privately practicing Clinical Psychologist, but due to the Gillard Government's Budget cut in mental health, could no longer see his Clin Psych and began seeing a young counsellor or psychologist in a Medicare Local (under the ATAPS system), who had no experience in dealing with complex problems, such as Post Traumatic Stress Disorder. The Medicare Locals, despite intentions to hire a Clinical Psychologist, have been unsuccessful due to both lack of pay and lack of benefits. What happens next? First off, Joe will need more than 10 sessions in a year. (If the government had made it mandatory for psychologists practicing clinical therapy to be Clinical Psychologist, this problem wouldn't exist). Basically, Joe will need to see someone with the expertise. Joe needs to go back to his Clinical Psychologist.

Fortunately, it's the beginning of a new year; otherwise, Joe would be in dire straits. Joe, in the new calendar year is entitled to see the Clinical Psychologist under Better Access to Mental Health. So, in this scenario, Joe sees the expert, a privately practicing Clinical Psychologist. But considering he might need weekly sessions now due to his trauma, which then moves into fortnightly sessions, which then moves into monthly sessions - after about 2-3 months they have no more option for therapy under the Better Access system.

What happens then? Joe is forced back to the Medicare Locals; under ATAPS or Flexible Care Package. Joe's therapy is going nowhere (due to the same problems, lack of expertise, lack of experience, no Clinical Psychologist). Joe is getting worse. Joe's depression now requires medication and intervention from a Psychiatrist (which wasn't necessary under the guidance of the Clinical Psychologist). Joe has been forced to go into a residential treatment facility to monitor his depression and sucidality. Imagine Joe's mental health state now. Imagine the costs to the Australian population now!

After Joe is released, he struggles until the next year, when he is again allowed 10 sessions with his privately practicing Clinical Psychologist (which have to again start out weekly, or bi-weekly due to the stuff up of being 'treated' by a fresh out of Uni psychologist)! Eventually,

Joe gets so bloody frustrated with the system (remember, this is you, your friend, your partner, your child) and sadly becomes one of the statistics and commits suicide.

It's not just a scenario. My father died as a medical consequence of his bi-polar depression. He became an alcoholic and died of liver cancer. My stepmother and two close high-school friends all committed suicide. None of them had proper mental health support. My father and stepmother had been to a Psychiatrist and separately were in a residential treatment facility for a month, but none of the four had therapeutic support by a Clinical Psychologist. If that scenario was your family, you would want the best service available with the aim of ultimately recovery or at least their ability to manage life and to work within their constraints of their mental illness.

My recommendation, as I said before, is simple: Treat Clinical Psychologists as the experts they are:

- If the government is really concerned with recovery, don't limit the number of sessions for Clinical Psychologists. Allow Clinical Psychologists' to see patients as many times as a Psychiatrist can. Clinical Psychologists' follow the code of ethics, including to do no harm and to not over service a patient.
- Encourage mental health services to be run by Clinical Psychologists' who have expertise in the field, who can provide supervision to their less experienced colleagues, the Psychologist.
- Under the Medicare System, pay Clinical Psychologists properly, as experts in the filed of mental health. If anything, increase the rate for the Clinical Psychologist, rather than do what a large lobby group (AAPi) is pushing towards: a one tiered system based upon the expertise of the lowest common denominator...
- Meet world standards by mandating that to practice as a clinician, practitioners must be an endorsed Clinical Psychologist, as defined by the PsyBA (Psychology Board of Australia).
- Eliminate the need under a Clinical Psychologist for the requirement for Mental Health Care Plans, for those suffering from complex mental health problems.
    - If the patient has a GP, the Clinical Psychologist and the GP are most likely already talking about the patient.
    - Some patients don't have a GP but need mental health therapy.
    - Many patients, especially in rural Australia, cannot get in to see a GP for weeks, or longer for those who don't have a GP.
    - Allow Clinical Psychologists, in addition to GPs and Psychiatrists, to write Mental Health Care Plans and refer on less complex problems to others.

  (This reduction would reduce the demand on the already over burdened GP, thus it would reduce their demand, less infrastructure and plans to relocate GPs to rural areas would be needed).

Thank you for your time. Below are some interesting statistics from SANE Australia:

Regards,
Name Withheld

SANE AUSTRALIA

FACTS AND FIGURES ABOUT MENTAL ILLNESS

How many people experience mental illness?
Around 20% of adults are affected by some form of mental disorder every year.

Anxiety disorders affect around 14% of the adult population every year. Depression affects around 6% of the adult population every year. The remainder are affected by substance abuse disorders, psychotic illnesses such as schizophrenia, personality disorders, and other conditions. Many people have more than one diagnosis.

How many people are disabled by mental illness?
Around 3% of adults are psychiatrically disabled by the effects of mental illness.

Some people are so severely affected by mental illness that they become psychiatrically disabled. Schizophrenia can be a particularly disabling condition for some: this is a persistent form of mental illness that affects approximately 1% of Australians at some stage in their lives.

Does mental illness run in families?
Most people with a mental illness do not have family members with the illness.

For some mental disorders there does not seem to be a link at all. For others, such as schizophrenia and bipolar disorder, a predisposition to the illness may be inherited – but even then, it is only one of several factors. The causes are not fully understood. It is likely that such mental disorders involve a biochemical imbalance and can be triggered by such things as stressful life events, drug abuse, hormonal changes or physical illness.

Is mental illness life-threatening?
Mental illness itself is not life-threatening.

However, up to 15% of those seriously affected by mental illness eventually die by suicide (compared to an approximate figure of 1% for the whole population). Effective, ongoing treatment is essential to minimise the risk of suicide.

What are the chances of recovering from mental illness?
Most people with mental illness recover well and are able to lead fulfilling lives in the community – when they receive appropriate ongoing treatment and support.

However, only about half of those affected actually receive treatment. The maJoerity of people who develop anxiety disorders and depression improve over time with appropriate treatment and support. About 80% of people diagnosed with bipolar disorder also improve

with ongoing treatment and support. The long-term outcome for schizophrenia can be better than many assume, especially where access to good treatment is consistent. About 20% of those diagnosed have an episode or two, then never experience symptoms again. About 60% improve over time and, with support, can live independently. For about 20%, symptoms are more persistent, treatments are less effective, and greater support services are needed.

What are the figures?

- Nearly half (45%) of the population will experience a mental disorder at some stage in their lives.
- Almost one in five Australians (20%) will experience a mental illness in a 12-month period.
- During a one-year period, anxiety disorders will affect 14% of the population and depression will affect 6%.
- Depression is one of the most common conditions in young people and increases during adolescence.
- At least one third of young people have had an episode of mental illness by the time they are 25 years old.
- Research indicates that people receiving treatment for a mental illness are no more violent or dangerous than the general population.
- People living with a mental illness are more likely to be victims of violence, especially self-harm.
- Mental illnesses are not purely 'psychological' and can have many physical features.
- Anyone can develop a mental illness and no one is immune to mental health problems.
- Most people with mental illness recover well and are able to lead fulfilling lives in the community when they receive appropriate ongoing treatment and support.
- Women were more likely than men to use services for mental health problems. Approximately two-thirds of people with a mental illness do not receive treatment in a 12-month period.
- It is estimated that up to 85% of homeless people have a mental illness.