

Dear Senate Committee

I would like to make comment on the matters set before the committee as a registered psychologist (MAPS) and as a sufferer of schizophrenia and major depression. Although I have previously worked as a research assistant to the Australian Psychological Society, this submission DOES NOT represent their views.

- a) the Government's 2011-12 Budget changes relating to mental health;
- (b) changes to the Better Access Initiative, including:
 - (i) the rationalisation of general practitioner (GP) mental health services,

The proposed expansion to the roles of GP in superclinics undermines public confidence in their faith that the medical system is infallible. This faith is what is required for access to services to operate properly. Doctors are given minimalist training in counselling as opposed to allied health practitioners, psychologists and psychiatrists who have it as a foundation to their entire training. Doctors play an invaluable role in referral to allied health professionals and this is their strength which should be maintained regardless.

- (ii) the rationalisation of allied health treatment sessions,

The restriction of 6 sessions of counselling to be rebated by Medicare is based on an out of date crisis intervention model. Nowadays it is recognised by experts in the field that in instances of trauma, though it may be counterindicated immediately after a trauma, it has been found that most cases of post traumatic disorder are requiring more than 6 sessions of structured counselling. The cynicism exhibited by the Federal Government in deciding costing for the allied health after the bushfires show that Black Saturday survivors have had minimum appropriate psychological support. The formula used to decide who gets what is based on factors like number of sessions required times by the psychologists fee is flawed because of its time limited nature when distress from these sorts of events is unable to be quantitatively measured. The reliance purely on the Australian Psychological Society as a pool of expertise excludes the large number of experts who are allied health professionals that are not psychologists nor members of the APS.

- (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

The impact of the changes to the medicare rebates may mean that client numbers will drop, not because of decrease of need, but due to challenges such as financial issues. Again these numbers are not able to be quantified. The two tier rebate structure has caused a massive split in the psychological profession. For the purposes of this debate I acknowledge I have a bias being a counselling psychologist, not a clinical psychologist. Clinical psychologist are receiving the bulk of community work because of the status of being seen to be more worthy because of the higher rebate. A preferable alternative is to make the rebate structure level for all branches of psychology. The clinical cum medical model of the profession is not representative of what psychology has to offer. People who are clients of counsellors have reported good outcomes, comparable to that of clinical psychologists .

Scott Miller an American expert on client outcomes (see book "the Heroic Client) along with many other researchers have shown that the theoretical models of counsellors only matter at around the 30% mark for effectiveness. Predominantly it is the relationship between client and counsellor that matters the most, with Carl Rogers model of supportive listening being a universal amongst the profession. This relationship can be damaged very easily. The two tiered system encourages expectations that are false- that clinical psychologists are better than others.

(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 impact of these changes mean that counselling is less accessible in the long term for patients because of the financial burden. Psychologists are then required to represent their patients in a way that satisfies referral needs that may misrepresent how well or unwell their patients actually are in order for the patient to get the best treatment and for a longer period of time. This disempowers clients working out for themselves what their possible diagnosis may be. Personally I have used public allied health and private health service providers and if I had to wait for service my condition would deteriorate in a number of hours. The public and private sector have waiting lists and more often than not cannot see patients in a timely manner. Being unfinancial people means they will not be able to access either programs. The gap in service provision has been identified as being a significant barrier to accessing services. With less sessions and a decrease in possible care with counsellors many are less likely to access the service to begin with. The expectation of patients that they be looked after in an ethical way is threatened by these changes. The choices that patients make for their care is influenced by financial issues and they make erroneous assumptions that have detrimental effects such as choosing a provider because of price rather than matched to their psychological needs.

(c) the impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program;

The scheme in its current form is fantastic despite the division between clinical and counselling psychologists. It has allowed more people to access professional help in a more appropriate manner than before. However the proposed changes will decrease this effectiveness. As a user of both private and public health services I have found that the public system is underfunded which leads to long waiting lists, and substandard accommodations like the John Cade wing at the Royal Melbourne hospital. The nursing staff in both private and public settings are magnificent and all allied health professions deserve to be treated and given equal recognition for their service.

(d) services available for people with severe mental illness and the coordination of those services;

The whole psychiatric system requires an urgent injection of funds to cut down wait list times and the hiring of appropriate staffing tailored to the needs of the community. I support Patrick McGorry's statements to this effect. The coordination of services will greatly improve with a single contact point for medical records and for referral if enough caution to the Privacy Act is adhered to. As someone with a mental illness I have had my treating doctor change my level of risk from medium to low to allow me to take leave and this was undocumented because there were not sufficient time or opportunity for the staff to check. A prime example of multi disciplinary single point access service is headspace for youth services.

(e) mental health workforce issues, including:

As someone with a mental illness I have had my treating doctor change my level of risk from medium to low to allow me to take leave. The communication between departments and different allied health staff is dreadful and not encouraged by the silo mentality by Human Services both Victorian and national. Patients who are transferred from one hospital to another like myself are pressured and under pressure by nurses and intermediaries who do not have time because of Human Service restrictions and report mechanisms. These include the unit costing of having to write down every 5 minutes what one is doing at work for departmental costings which often has no correlation with the services being provided.

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

As stated previously the two tiered rebate system has split the profession apart with more time being dedicated to in-fighting between the APS and its psychologist members than more relevant consumer needs. The APS does not represent all psychologists, a factor overlooked when peak bodies and the government request information about psychologists.

(ii) workforce qualifications and training of psychologists, and

Credential creep has already occurred with the changes mooted by the APS regarding psychologist training and the requirement of having a masters degree in order to register to become a registered psychologist. The confusion caused by the proposed changes and also the differences between the APS and the newly made national psychological registration board suggests that not only psychologists are unable to sort out what they have to do to maintain their qualifications, aspiring psychologists are affected as well. The currently imposed self reporting mandated professional development and logbooks have criteria that are onerous and time wasting. The lack of widespread consultation by the APS about the professional development requirements is to be abhorred. The current schemes also prevent entry from equity groups because of cost and accessibility- typically in Psychology it is those from a lower socio-economic background, those who have a psychiatric disability and rural and regional areas that have difficulty gaining access and maintaining retention to

completion of their respective degrees. The advantages of having matched characteristics to ones clients is not to be sniffed at and typically the same characteristics increase the salience of the counselling relationship and potential success. Psychologists are predominantly women with anglo-celtic backgrounds, with middle class aspirations and tertiary qualifications. Typically their preference like doctors is to work in inner urban settings.

(iii) workforce shortages;

Liam Farrelly is a psychologist I'm familiar with who has had to close down His low cost counselling service in Footscray because of the impact on his practice with the changes to the scheme. The Western suburbs are a high risk and need area and Liam is unable to service them continually because he cannot afford it.

(f) the adequacy of mental health funding and services for disadvantaged groups, including:
(i) culturally and linguistically diverse communities,

As stated above the high risk areas and demand for services come from CALD, lower socioeconomic, refugee, indigenous, young men, youth and elderly, and disability to name a few. The need outstrips demand, though this has yet to be quantified anecdotal evidence, suggest that there is not enough service to meet needs including the unmet need that we are not aware of.

(ii) Indigenous communities, and

Please see the indigenous submission from the Australian Psychology Society- I fully support their stance.

(iii) people with disabilities;

There is a lack particularly at the tertiary education level for disability support particularly effective psychiatric support. There is more funds available than is recognised despite the recent developments of Mental health summits aimed at tertiary levels, the instalment of a new Minister for Mental Health both at state and federal levels, and the work of ORYGEN and Patrick McGorry which I also fully support. There is a lack of representation of sufferers of mental illness in all public walks of life and this includes the numbers of consumer consultants which is an initiative to be admired. Only one university to my knowledge has a mental illness support group and guide and conducted a project to investigate clients with complex needs. There are mental health initiatives in the tertiary sector but they are primarily concerned from a risk prevention framework rather than an equity framework which is very unfortunate though understandable.

(g) the delivery of a national mental health commission;

This commission though catalysed by concerns of risk to the community and the forthcoming elections should be mandated to be a mental health consumer initiative.

Consumers should be represented at all levels of the commission and advocated for in the strongest sense of the word. Diversity in panel members needs to be enforced to ensure a fair outcome and the author(s) or public face of the commission need to be someone who is public about their mental illness or diagnosis for it to have credibility.

and

(h) the impact of online services for people with a mental illness, with particular regard to those living in rural and remote locations and other hard to reach groups;

Online services are a great initiative for all clients wherever they are. It is a good suggestion to support the NBN. However this may lead to the erroneous assumption that they can replace conventional services that traditionally have better outcomes than internet counselling. The impersonal nature of online counselling and the high degree of margin of error of this particular service delivery mode must be taken into account. These include- inability to form a genuine empathetic relationship for neither party is able to totally read body language in front of a screen, the easy ability to terminate sessions prematurely by turning the modem/computer off, the easy access for hackers to create havoc with both parties on line, the potential for the client to easily dismiss their problems and failing to communicate risk with the lack of body language, and emotional cues compared to face to face interaction.

I hope the Senate Committee will take my views into account and I am happy to speak in support of my submission to the committee.

Yours sincerely

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