Thank you for the opportunity to provide some views to the Productivity Commission with regard to Mental Health. I am a psychologist with 38 years experience across public and private sectors. I have worked in my own full-time private practice over the last fourteen years. Much of my work over most of my career has focussed on assisting adult clients with effects of childhood trauma and abuse. I worked with children and adolescents for several years earlier in my career.

Optimal Mental Health

Emotional well-being and security form the basis for good mental health, and is founded in early experiences of attachment with those around us. Understanding ourselves and our internal worlds as well as our interpersonal connections is important for emotional well-being and security.
Daniel Siegel (2004) has described secure attachment in the following way:
"Secure attachments are thought to occur when children have consistent, emotionally attuned, contingent communication with their parent or other primary care-giver. Relationships that provide contingency, especially at times of emotional need, offer children repeated experiences of feeling connected, understood, and protected." Approximately one third of people grow up with insecure attachment and suffer the detrimental effects and dysfunction that this brings to their adult relationships and their relationships with their children, as well as those around them in their communities. However, it is possible to develop "earned" security in adulthood, through good longer-term therapy and/ or good relationships with others as an adult, through making sense of our lives and forming a coherent life narrative. Siegel (2009) states " When it comes to how our children will be attached to us, having difficult experiences early in life is less important than whether we've found a way to make sense of how those experiences have affected us. Making sense is a source of strength and resilience. In my twenty-five years as a therapist, I've also come to believe that making sense is essential to our well-being and happiness."

This fits well with the psycho-social approach to mental health adopted by the Power Threat Meaning Framework which has recently emerged from the British Psychological Society Division of Clinical Psychology, and is gaining widespread use and acceptance in UK and other parts of the world. This offers an alternative to traditional models such as medical psychiatric diagnosis which can be disempowering and unhelpful to clients, as well as stigmatizing. Instead the PTM Framework poses the following questions which can be applied to individuals, families or social groups.

1. What has happened to you? (How is power operating in your life?)

2. How did it affect you? (What kind of threats does this pose?)

3. What sense did you make of it? (What is the meaning of these situations and experiences to you?)

4. What did you have to do to survive? (What kinds of threat response are you using?)

Two further questions help us think about what skills and resources people might have and how they might pull all these ideas and responses together into a personal narrative or story:

1. What are your strengths? (What access to Power resources do you have?)

2. What is your story? (How does all this fit together?)

It is to be hoped that this kind of approach will become more fully accepted and widely adopted within mental health in Australia in order to promote optimal mental health.

Childhood Abuse, Neglect and Trauma

As discussed in the Issues paper, child abuse and neglect is prevalent, has a devastating impact on mental health, and has enormous costs. The Adverse Childhood Experiences Study which commenced in 1995 measured 10 types of childhood trauma, and found that almost two-thirds of the 17000 participants in the study had one adverse childhood experience or ACE and 87% had more than one ACE, and more than one in five had three or more ACEs. The ACE Study revealed a link between childhood trauma and chronic disease in adulthood, as well as social and emotional

problems in adulthood. It has revealed links to early death from both suicides and chronic disease. Of these ten ACES which formed the study, five reflect personal trauma - physical abuse, verbal abuse, sexual abuse, physical neglect, and emotional neglect. Five are related to other family members: a parent who's an alcoholic, a mother who's a victim of domestic violence, a family member in jail, a family member diagnosed with a mental illness, and the disappearance of a parent through divorce, death or abandonment. All of these traumas or ACES are to do with attachment, connection and relationship with others, and how it affects one's sense of one's self.

Prevention of Mental Health Issues

Prevention and treatment are both very important in addressing mental health issues which often stem from childhood trauma. It is important that schools incorporate measures to reach out to children in need of psychological assistance, and to educate children more generally about psychological issues, including healthy attachments, healthy boundaries, assertiveness, social skills, empathy, and a healthy sense of one's self. If psycho-educational components can be introduced into the school curriculum, this can encourage children to discuss feelings if needed, and those at risk can be assisted more quickly. It may also assist in reducing bullying, and foster better relationships amongst children, which can often last into the future and provide resilience against mental health issues into adolescence and adulthood. The use of mindfulness and meditation in schools as well as workplaces would also be a good measure to provide development of self-reflection and promote good mental health in individuals and communities.

Treatment of Mental Health Issues

Available and appropriate psychological treatment is very important to address mental health issues, both for children and adults.

Hubble, Duncan and Miller (1999) have comprehensively explored and reviewed research literature on the issue of what makes therapy effective in their book The Heart & Soul of Change: What Works in Therapy. They have highlighted something that most therapists and clients intuitively know, and that is that one of the most important factors, over and above techniques used, that makes therapy effective, is the therapeutic relationship.

A Green paper has recently been released by the Australian Psychological Society as part of the Medicare Benefits Schedule (MBS) Review. I believe the model recommended by the APS in this paper is extremely ill-considered, and I wish to discuss problems with this model and suggest an alternative model.

The model proposed by APS is a three-tier model, where clients seeking services under Medicare are allocated to one of three levels according to the severity of their need, and whether this is mild, moderate or severe as assessed by their GP. This raises the first serious problem, as this means that clients can be stigmatized in this process and that diagnosis can be used or misused in this process. Vulnerable clients presenting for help will need to be initially categorized which may discourage them from further proceeding to seek help.

Secondly, APS has determined, without any evidence to support this determination, that only some psychologists who happen to have an "endorsement" (or, if psychologists are rural, are willing to undertake a "practice certificate" involving a minimum of 40 hours of training), are to treat clients in the severe range under Medicare. However, the system of "endorsement" is a relatively new system and does not take into account that many psychologists had years and decades of experience prior to this system being introduced, and never foresaw the need to seek "endorsement" as there was never any requirement to do so. Under this proposed APS model, many psychologists who have effectively and successfully been treating their complex clients for years or decades would no longer be able to see these clients under Medicare. Therefore these clients would lose their long-term psychologists or their choice of psychologist. This would be very damaging for some clients, and could lead to deterioration in their mental health, and in some cases, increase their suicide risk.

Thirdly, throughout the course of their therapy, clients may have to change therapists should their needs change (and this is the natural course of therapy that needs will change up and down depending on life stressors and circumstances), which would be very disruptive to the therapeutic process as the therapeutic relationship built up with one therapist would need to be abandoned for the client to move up to another level of need. This completely flies in the face of what we know about the needs of clients in therapy, which is to have a consistent, reliable relationship with one therapist to be able to work through their issues, and so this would have the potential to cause great harm for clients. Particularly because this switch would have to happen at a time when the client is in greatest need through, for example, a crisis, or a new life trauma, or because they may perhaps become suicidal, which is when they need their long-term or known psychologist most. This also would appear to contravene our duty of care to clients to have to refer them on to a different psychologist at this point, and there would be unnecessary additional costs, as well as possible legal issues as to professional responsibility, in cases where having to refer to a different level psychologist, results in detrimental consequences for clients eg deteriorating mental health or even suicides.

Fourthly, APS has proposed that the number of sessions per year available to clients increases as the client ascends the stepped care model from mild (10 sessions) to moderate (20 sessions) to severe (40 sessions). Rebates would vary depending on levels (as well as depending on which sort of psychologist). This has the potential to create disincentives for clients to embrace visible progress, as to do so would mean that their sessions reduce when this may not be in their interests, and they may get a lower rebate if they improve to a lower level. This system would impede, cloud or complicate their actual progress in therapy. It would be unnecessarily costly and unwieldy, and would likely confuse statistics with regard to client progress, or client categorization/ allocation to levels.

Fifthly, because of the demand for the relatively fewer “clinical” psychologists, there would be a long waiting period for a client in “severe” need to see one, while legitimately qualified and registered, highly experienced, skilled and competent psychologists, who happen to not have “endorsement” would be put out of business. This is obviously potentially harmful for clients, and makes no sense from a productivity viewpoint.

Psychologists without “endorsement” (who number approximately two-thirds of psychologists) have been treating clients with severe disorders for the past 12 years under the Better Access Scheme of Medicare, and there is no evidence of differences in treatment outcomes by these Psychologists compared to that of “endorsed” psychologists, as shown and discussed in the Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative by Pirkis et al in 2011. There is no reason or necessity to discriminate against psychologists without “endorsement” or to have a complex, costly and unwieldy model built upon this discrimination, which appears to be to to the detriment of clients.

I would suggest that a more effective and workable alternative model would be a simple one tier and one rebate system where all psychologists are rightly valued and utilized to assess and treat all clients, as they have all been trained, qualified and registered to do. After an initial standard number of ten sessions, further sessions could be requested through regular GP reviews depending on the individual needs of clients, and the maximum number of sessions could be capped at 40, but preferably 50 per year, since many clients with complex needs require weekly sessions. Many clients would not need to use all of these sessions available, and would only use what they require.

Thank you for the opportunity to present these views.

References

Adverse Childhood Experiences Study (1995), Centers for Disease Control and Prevention, California, U.S.

Division of Clinical Psychology of the BPS (2018), Introducing the Power Threat Meaning Framework.

Pirkis et al (2011) Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative.

Mark A. Hubble, Barry L. Duncan, Scott D. Miller (Eds)(1999)The Heart & Soul of Change: What Works in Therapy. American Psychological Association.

Siegel, Daniel and Hartzell, Mary (2004) Parenting from the Inside Out. Penguin, New York.

Siegel, Daniel (2009) Mindsight Change Your Brain. Scribe, Australia