



Counselling WA
Sharon Blake QMACA

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Response to The Mental Health Report drafting. Attention The Commissioners.

Thank you for facilitating the opportunity for the mental health sector to have a say in funding. This is a very important topic into WA's exploration on how we can best serve our community in the most professional, economical and evidenced based approaches possible to achieve the best outcomes for all Australians.

My name is Sharon Blake. For the past 20 years and I have been working with disadvantaged people and practicing in Counselling psychotherapy, Clinical Supervision and lecturing since 2006. I hold a Master of Counselling.

My role has taken me to many organisations that not only seek to work with those with mental health challenges but also as a trainer of post graduates in a variety of clinical positions from psychology, counselling psychotherapy, and social workers. (I was a guest lecturer at Murdoch University with year 4 psychology students covering counselling skills about 4 years ago. It was a 2-hour lecture. 7 of 40 students attended.)

Counselling is not diagnostic nor does it recommend medications. These are quite separate skills and require referring clients to the appropriate professional. Counselling is based on establishing a relationship with the client foremost, and provide a safe and respectful environment to explore, through various strategies (psychotherapy), not only behaviours, but the context of their development. It is this that makes counselling a strategy that is reparative on many levels and has the best opportunity to stop generational dysfunction.



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The major issues I deal with in supporting and empowering individuals to work through complex mental health issues include; neglect and abuse, childhood sexual, emotional and physical traumas, anxiety and depression, alcohol and drug addictions, suicidal ideation, cultural marginalisation and couples and family issues. These, no doubt, can be given many diagnostic labels, but I challenge if this is really in the best interest of the person experiencing difficulties. Certainly, as an initial intervention.

All of these issues anecdotally are increasing, as our mobile Society is becoming disconnected and impersonal, welfare punitive and often unattainable. With this, the gap widens as unemployment, homelessness, substance misuse, domestic violence, marginalisation, online and school-yard bullying and addictive gaming, all contribute to an escalation with individuals seeking help, as they lose the potential to integrate, thrive and prosper.

Due to the lack of real funding, agencies, community groups and NGOs, those who mainly work with marginalised groups, are forced to employ untrained individuals because of the low wages they can only offer. Trained appropriate staff in counselling are often out of their reach, or others employ psychologists (often new graduates) where they can double-dip the Medicare rebates. Since this rebate has been in effect, counsellors have lost their jobs to psychologists. Mainly newly graduated young people with little life experience.

With these factors in mind, we are faced with an ever-changing vista of complex challenges and as society becomes evidently difficult for a growing number of Australians, we must explore how, where, what and why we do, what we do. We have to be guided by clinical excellence and best practice modalities and protocols. To do this we must focus on evidence based approaches to intervene with individuals and families and maintain a healthy critique on what we may need to change, to improve outcomes and reduce mental health issues and violence.



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We also have to be open to change and examine our current systems and critique why we are facing ever more pressures and poor outcomes in certain interventions of which I will cite further in this document. Funding and distributing of existing systems and their efficacy, are key explorations.

My experience covers the groups/individuals I have worked with that include; The Personal Support Program for jobseekers that have mental health barriers to employment, (a very successful two-year program that has sadly been defunded), Relationships Australia, Aboriginal and offending youth programme, Drug and Alcohol, rehabilitation, men transitioning from prisons, women's health and domestic violence programmes.

A great deal of these programmes I have worked with are incredibly well meaning but the funding has always been ambiguous and programmes are ceased for a variety of reasons, but generally not around their efficacy. Historically the majority of funds for mental health, to date, are diverted to psychiatry, and the Medicare rebate subsidizing psychology, social workers, and occupational health workers for the provision of 'counselling.'

When we look at the financial burden to the state to fund these professions, which we are grateful for, at the same time we must acknowledge they are not always appropriate, and patient access is difficult, currently with long waiting lists. But by their very nature, even though they are expensive, they are short term which may make them attractive, but not humanistic. And we are left with some stark realities that we have a costly system that has too many bottle-necks to client accessing supports when they most require it, exacerbating future health care and often intimidating clients further.



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In short, we should be looking more at a preventative model of support rather than a last ditch crisis-based one which appears to be unable to cope with the amount of emergency referrals it receives each day medically driven and short-term for cost-effectiveness. Going by recent research, these approaches are enormously expensive and limited in long-term mental health. Diagnosis and medication can/are important, but the real work reaches way beyond this.

So, instead of maintaining the current systems and funding, we have to be creative and look at ways of increasing clinical outcomes within a budgetary framework that is long overdue for re-assessing.

We are faced with a question and possibly a solution, which could become a very client-focused and evidenced based solution. The question is why are counselling psychotherapists not utilised within our health system as our American, Ireland and some European clinical teams do? The evidence was reported in 2017 in the Atlanta USA, School of Medicine in a research paper entitled Evidence-based psychotherapy: Advantages and Challenges and I quote;

‘Evidence based psychotherapies have been shown to be efficacious and cost-effective for a wide range of psychiatric conditions.’

Along with this is Professor Richard Friedman of Clinical Psychiatry at Cornell Medical College article in The New York Times (2015), cites;

‘Psychotherapy has been shown in scores of well controlled clinical trials to be as effective as psychotropic medication for very common psychiatric illnesses like major depression and anxiety disorders’ He also adds;

‘In a meta -analysis of 34 studies., Dr R. Kathryn McHugh at McClean hospital found that patients were three times more likely to want psychotherapy than psychotropic drugs.’



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Friedman poses that psychiatry is facing a quandary, and that although there are newer drugs, they are proving to be no more effective. He is alarmed that clinical trials receive half the funding (In USA) but 'a mere 5.4 percent ...goes to psychotherapy clinical trials research.' He says there is 'no biological'... 'quick fix' for patients that have histories of trauma, sexual abuse, the stress of poverty or deprivation.

Friedman also observes that 'Personality disorders, like borderline and narcissistic personality disorders which are common and can cause impairment and suffering comparable to that of severe depression, are generally poorly responsive to psychotropic drugs, but are very treatable with various types of psychotherapy'.

Looking closer to home, we have the evidence on our door step that we need to be much more critical of what we do. In May 2019 the Australian & New Zealand Journal of Psychiatry (Volume 53, Number 5) displayed a graph on suicide and its steady rise, with alarm. The National Suicide Prevention Strategy, 2000, created the funding of a number of specific programs and 'increases in the uptake of pharmacological and psychological treatments for mental disorders in Australia.' The graph however plots the rise in suicides with 'the striking impression ... that past efforts appear to have made no discernible difference'. They pose the questions; 'Why have past suicide prevention efforts not clearly worked?' and, 'What should we be doing in the future that is different?'

Along with Australian, New Zealand and American research this dependency culture on psychiatry and psychology with the avoidance of including counselling psychotherapist's to be part of the solution. One may wonder at the gender bias of male dominated psychiatry and psychology, their strong and influential peak bodies and Big Pharma. There are so many well-trained counselling psychotherapist available Australia wide, we should be posing the question, when all the research points to the solution of counselling psychotherapy, why is the health sector



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not utilising them? Grass-roots services are financially weakened and therefore can only offer sub-standard services, yet this is a greater part of the solution we Australians continue to fail to implement.

The American Journal of Psychiatry (May 2019) published a study by Dr Markowitz of PTSD on veterans returning from war. '...the response rate to interpersonal therapy (63 percent) was comparable to that of exposure therapy (47 percent.) The comment that 'This study now gives clinicians a powerful new therapy for this difficult-to-treat disorder'. Imagine how many more studies [like this] might be possible if the federal funding of psychotherapy research was not so stingy.'

Please note that even our esteemed colleagues from Psychiatry are publishing the need for counsellors to be a bigger part of the solution. In an article by The Royal Australian & New Zealand College of psychiatrists, May 2004;

'In Australia and internationally, the cost of mental illness to the community in both human and economic terms is growing. Many psychiatric conditions are complex and severe, and involve significant co-morbidity. Many require psychotherapy [counselling], including intensive long-term treatment'. And it '.. is an important component of the overall treatment for the low prevalence disorders such as schizophrenia and bipolar disorder. Equally, psychotherapy is an important component of the treatment of high prevalence disorders such as anxiety, depression and substance abuse.'

I believe that we, as health professionals, must begin to work co-operatively, in a multi-disciplinary manner with everyone performing the roles they are specifically trained for. Elitism is unethical and should not be colluded with, particularly for the health of our society.



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I will not discuss really much around the percentage of psychiatrists or psychologist specifically trained to beyond a degree level in counselling psychotherapy skills, let alone the numbers that have engaged in their own therapy, but an exploration of this may give an indication as to the low take-up in counselling psychotherapy skills. Part of a well-trained counsellor psychotherapist's brief is to have several years of ongoing therapy and engage on a regular basis in clinical supervision for client best-practice interventions. The difficulty we have faced in psychiatry and psychology is the lack of take-up to go beyond a regular foundation skills-based training within their core training.

Foundation level skills are not appropriate for the clinical issues we are faced with, such as the most common intervention; Cognitive Behavioural Therapy (CBT). Simply changing how you think, behave or feel, although useful later in therapy, not only is simplistic but quite dangerous and demeaning.

As we critique who does what and how we should move forward, hopefully we can now assess that our current system requires reinvention from the ground up.

A new system is critically worth considering and instead of throwing more money at existing services, look at the efficacy of treatment and prevention of counselling and the economic facts that most counsellors charge \$100 per 55 minute one-to-one session whereas a psychiatrist can charge anywhere between \$500-\$750 per hour psychologist up to \$300. The math's is obvious but the interventions are different. We must focus on the outcomes.

Of course, it's important psychiatry and psychology remain as an integral part of the solution but how their work would be made easier, more humanistic and effective if Australians had access to a counsellor funded programme prior to them engaging (often in a crisis) to the existing services that have long wait lists, over booked and often ineffective.



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In particular, with children, foundation issues such as parenting, trauma and diet need to be the first port of call. Yes, we can take the view that an anti-depressant pill might be cheaper in the short-term than a counselling session, but rather than have someone languishing in abject low-level functioning for several years on potential state subsidies, and the social implications of a life played out dysfunctionally, we should focus on empowering the patient to become a thriving productive empowered individual.

In summary, we can no longer avoid both the clinical and research evidence that counselling in WA and in the whole of Australia has been the poor cousin to both psychiatry and psychology, and ask why has this been allowed to happen? I'm advocating, as a counselling psychotherapist of many years, that Australians deserve a better service, a better system. One that pro-actively engages with each individual and is facilitated to become just like each one of us here today, and one that with current funding requires tweaking and a redistribution of the funding, and intervention will be more fruitful and our citizens more mentally healthy.

But most importantly, Australia should be the world leaders in showing that counselling is available to all citizens well in advance of a crisis manifesting into the interventions of schools, police, ambulance staff, psychiatry and psychologists. A great deal of what is required is someone you can actually talk to, the sanest intervention is always prevention, and that mental health issues are best in a client-focused environment.

Counsellors and counselling organisations are ready and willing - it just needs everybody to make the leap and focus on making this happen, and give counselling psychotherapy its rightful place in our society, for all our sakes.

Thank you.

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