

Australian Productivity Commission
Inquiry into Mental Health

Dear Commissioners,

Thank you for this opportunity.

I am a registered Psychologist, Medicare provider and registered with the Australian Health Practitioner Regulation Agency. I am also a member of the Australian Association of Psychologists, and Eye Movement Desensitisation and Reprocessing Association of Australia.

After working in the public mental health system, I left my job at Child and Youth Mental Health Services to work in private practice 6.5 years ago. Initially I worked as a subcontractor in 2 different private practices, with supervision. I started my own practice 15 months ago. To review my practice and ensure that I offer the best level of service, I engage in monthly paid supervision for Case Consultation, engage in regular workshops and webinars for professional development, read articles and books relevant to my practice, attend monthly peer network meetings where case consultations or professional development activities are offered, and attend monthly peer support meetings. I feel that it is necessary for me to make the aforementioned statements in order to dispel myths that private practicing, registered Psychologists practice in an unregulated fashion.

As a registered Psychologist, I represent 70% of the population of Psychologists. Clinical Psychologists represent 30% of the industry. To my dismay, there have been ruptures within the industry over the years. The Australian Psychological Society (APS) argue for higher rebates for services offered by a clinical Psychologist. Economically, this seems senseless as there is no evidence to suggest that there are improved outcomes for consumers serviced by Clinical Psychologists. In fact, evidence suggests that there is no statistical difference in outcomes between Registered and Clinical Psychologists:

<https://reformaps.org/second-evaluation-of-the-pirkis-et-al-2011-study/>

The APS has recently released a Green Paper as part of the Medicare Benefits Schedule (MBS) review. The recommendations propose a 3-tiered system such as a Stepped care model. There is no evidence supporting such a model as being effective in the provision of mental health services to the public. The recommendation is that consumers be classified by a Doctor as having either 'mild', 'moderate' or 'severe' mental health conditions, and that Medicare rebates depend on these classifications. Can the Commissioners imagine asking Cancer patients to accept different Medicare rebates dependent on the severity of their cancer? Can the Commission contemplate those members of the public with heart conditions accepting varied rebates to see a Specialist dependent on the severity of their condition? It is not a recommendation that would be accepted for any physical health condition, so why should it be applied to people with mental health conditions? The recommendation of the APS Green Paper stipulates that when a consumer's circumstances change, i.e. their mental health condition changes from 'mild' to 'moderate', that they have to return to present to the Doctor to be re-referred on the new classification to the

Psychologist. The APS suggests that only Clinical Psychologists may offer services to those presenting with 'severe' mental health conditions. This limits the consumer's access to only 30% of the industry. The risks are long waitlists, increased travel time for the consumer, as the majority of Clinical Psychologists work in urban areas, and decreased access to the most vulnerable consumers. This recommendation also reduces client choice in practitioner and presents a complex and confusing model to the most vulnerable consumers to navigate. This is disruptive, inefficient and for those consumers managing trauma or issues with functioning, highly risky.

Registered Psychologists have already been marginalised by Centrelink. Consumers will no longer have reports accepted written by Registered Psychologists to support access to the Disability Pension or relevant services. The cost & impact comes to the consumer. It is fair to assess that a person applying for a Disability pension or relevant services with Centrelink is more likely to present with difficulties in functioning, vulnerabilities and risks. It is fair to assume that a person with this presentation is more likely to be impacted by mental health issues, either as the primary condition, or secondary to a physical health condition. Therefore, the burden is increased for the consumer to have to find and engage a Clinical Psychologist (only representing 30% of the industry therefore less accessible), in order to get access to a report to support their cause with Centrelink. In some cases, this has meant that a consumer engaged with a Registered Psychologist has had to also engage a Clinical Psychologist for the sole purpose of reporting to Centrelink, be referred on and dis-engage from preferred practitioner, or not achieve this tasks at all, placing them at increased vulnerability as they aren't able to access the necessary assistance from Centrelink.

I am a certified EMDR therapist. EMDR therapy is considered by the World Health Organisation and the Department of Veteran Affairs as evidence-based and the most effective treatment for trauma. As an EMDR therapist, the majority of my clients would be classified as 'severe', and under the proposal of the APS, would need to be re-referred on to a Clinical Psychologist should their recommendations be put forward by the Government. My main concern when working with a consumer is to establish a therapeutic relationship first and foremost. Therapy is not successful without a therapeutic relationship. The ramifications of clients being referred on to a Clinical Psychologist against their wishes, simply because policy states, would be risky for those who already present with developmental trauma and thus attachment issues (including abandonment/ rejection issues). I consider that the recommendation by the APS pose serious harm to consumers with mental health conditions.

I have read recent rhetoric of increased spending on mental health in recent years in the context that somehow the funding isn't being utilised properly. There needs to be acknowledgement that mental health has historically been poorly funded. Therefore, I am not surprised at the alarming statistics of a 9% increase in Suicide rates in Australia. Funding for mental health attracts a very small portion of Federal funding for health, and yet mental health conditions are high in prevalence among the Australian public. I have read rhetoric that increased spending assumes that the current system is failing. Whilst I support the need to review mental health servicing, I encourage Commissioners to consider psychosocial factors behind increased need for mental health service spending.

Australia is a growing population, therefore an increase in spending on the mental health sector can be expected. Furthermore, the stigma of accessing support and help for mental health conditions has decreased over the years, therefore consumers are more willing than ever before to access support. This should be celebrated.

There also needs to be consideration given that there has been a significant increase in the prevalence of chronic disease. Mental health problems are co-morbid of physical health problems, therefore an increase in demand for mental health services is to be expected, particularly in lieu of this sector being significantly under-funded in the first place.

As I am not an anthropologist, I cannot comment on the complex psycho-social factors that are driving the increase in demand for mental health services, I can only make suggestions. However, I know that there is a significant demand for mental health interventions. I have been working at a 50% increase in capacity to what I would like to in order to try to meet the demands of referrals coming to me from G.P.s. My Calendar is fully booked 6 weeks ahead and this is and has been typical of my workload for the past years. I have recently had to close my books and am not taking on any new referrals until I reduce my caseload. I am still getting phone calls of people in desperate situations looking for support, advising that other Psychologists who have been contacted have long waitlists. There seems to be a preference among the public for access to single Practitioners as opposed to services. The preference seems to be driven by the desire, as reported by clients, to engage in personalised, non-intimidating and relationship based services from private practising Psychologists. There is a reported desire among my practice members not to have to recount their experiences to several practitioners in order to seek treatment. The benefit of private practise Psychologists are that consumers have choice about who they engage with, that speciality/ niche competencies can be offered, and that the therapeutic environments can be confidential. Larger services have other consumers in waiting rooms, admin staff, other practitioners, and service workers in attendance, which offers a challenging environment to those with anxiety disorders and trauma-and-stressor related disorders.

I provide service to practice members who have survived the worst trauma imaginable. Some of the experiences my clients have survived include:

- sexual abuse by several adults over the course of their childhood
- histories of family violence in childhood, and then long term relationships in domestic violence
- veteran's surviving systemic abuse in a system where they cannot defend themselves or access help without the permission of an officer
- pervasive childhood abuse including physical and emotional
- Torture and death threats
- Gang rape
- Migrants who grew up in civil war, witnessing mass killings of citizens
- Multiple tragic losses of family members

The Better Access Scheme used to offer 24 sessions per calendar year for access to Psychologists. This got reduced to only 10 sessions per calendar year, and has stagnated at the same rebate rate of \$84.80 for a 50-minute session for the duration that I have been in

private practice. This is simply not good enough for the consumer. 10 sessions a calendar year is less than 1 session a month. Those trauma survivors I have just mentioned above are expected under the Better Access Scheme to only be able to access rebates for 10 sessions a year in order to contain and support their presenting issues from such complex histories. It is only in the mental health sector that such limitations on the number of sessions a consumer can access is placed. For example, cancer patients are not told that they cannot access chemotherapy beyond a certain number of treatments. I highly recommend more consideration is given to allow the public to access as many sessions as they need, without a cap, to either recover from an episode of mental health problems, or continue to engage in ongoing, long-term therapy to contain and support them in navigating a life following complex trauma. Categorising consumers on need only offers further complexities that vulnerable consumers have to navigate. I highly recommend that this support be accessed by offering a single rebate to all consumers, whether accessing support from a registered or a clinical Psychologist. The Commission can perhaps understand that consumers are not going to use more sessions than necessary. Those who are well, are going to have preference to spend their time in other ways other than visits with a Psychologist. So why place a cap on sessions in the first place?

The Medicare rebate for a registered Psychologist is \$84.80 for a 50-minute session. Firstly, I would like to assert that a 50-minute session is often not long enough for the type of clients who have experienced the traumas listed above, particularly for the initial assessment appointment. Therefore either, complex clients are not getting sessions that are long enough to meet their needs, or Psychologists offer longer sessions than what they are financially compensated for. The latter has been the case in my private practice. In order for a Psychologist in private practice to offer their interventions, the following tasks need to be completed:

- Preparation for the session
- Note writing post the session
- Liaison with other stakeholders
- Case consultations with stakeholders
- Case consultation with supervisors
- Admin tasks such as appointment scheduling, emailing, appointment reminders, invoicing etc.
- Engagement in professional development
- Reading up on relevant topics etc.

The list above are tasks that a Psychologist in private practice does not get paid for. Therefore, at a rate of \$84.80, it is obvious that bulk billing is not financially feasible for Psychologists in private practice. This means, that often Psychologists charge a higher rate for a session, and the consumer is left to be out of pocket a gap fee. My recommendation is that the Medicare rebate be increased significantly, in order to benefit the consumer, and in order to benefit and fairly compensate a private practising Psychologist for their intervention. As there has been no evidence to support a difference in outcomes between registered and clinical Psychologists, I support a single tier rebate for all consumers seeking treatment from whichever Psychologist they choose to engage with.

I recommend that the Commission considers findings from studies related to the Adverse Childhood Experiences (ACE) questionnaire. The impact of developmental trauma is significant to a person, both for their mental and physical health (which actually should not be treated as separate if sufficient health care is to be offered), and therefore has implications on health service delivery. Current mental health funding does not effectively support people with developmental trauma. I strongly recommend the provision of services for early intervention, primary prevention such as easily accessible parenting courses, resources and information to manage the risk of developmental trauma for children. While Australia faces significant problems with alcohol and other substance abuse, domestic violence, child abuse, and increasing academic pressure on children at school, the risk of developmental trauma for children continues to be a factor that will perpetuate an ongoing high demand for mental health services for decades to come.

Oftentimes, I have new clients referred to me by a G.P. who have been on anti-depressant medication for several years with no recent review of the medication. Clients have reported little or no effect of the medication but continue to take it without advice to do so otherwise. Some of these clients have previously been managed by Psychiatrists and prescribed medication but not been referred to a Psychologist. Some clients report to me that they have been prescribed medication by a G.P. and were unaware that they could be referred to a Psychologist. I strongly recommend that the Commission look into this issue further.

In my 6.5 years of providing psychological intervention in private practice, I have facilitated (recommended to the G.P.) to make a request and recommendation for a hospital admission for a client due to risk of harm to themselves. Both times, the clients were voluntary and willing to be admitted. Upon admission, the hospital made no contact for background information. Upon discharge, the hospital did not notify me of the discharge. On both these occasions, the client shared my details with the hospital and requested that I be contacted. It would be helpful if the hospital at the very least cc'd the treating Psychologist on the reporting to the G.P. when the client has given consent to. I support recommendations that greater communication between stakeholders occurs.

During my years in private practice, there have been numerous instances where I have recommended the involvement of a Psychiatrist to the client. I have offered this by providing a list of names of local Psychiatrists and suggestion that the client schedule an appointment with the G.P. and seek their opinion, referral suggestions and referral letter. Each time the client has been willing. On numerous occasions the client has returned for further sessions with me, as planned, and advised that they met with the Psychiatrist and offered me consent for me to share information with treating Psychiatrist. From this point onwards, I cc the Psychiatrist at each 6th session and 10th session report (as per the mental health care plan) and share any relevant correspondence about the client. If necessary I make phone calls of offer myself for a case consultation. It has been my experience that the communication received from the treating Psychiatrists has been very poor. I am not included in their reports to the G.P. and the liaison is almost non-existent from their end. I support recommendations that Psychiatrists be instructed to liaise and share information with the treating Psychologist when clients have given consent to do so. On two occasions, when I have successfully secured a case consultation with a Psychiatrist and G.P., with the

only Psychiatrist I have ever liaised with willing to do so, I have offered my time free of charge while the G.P. and the Psychiatrist have been able bill for the case consultation on the Medicare benefits schedule. There is no such item for a Psychologist. I support recommendations made that Psychologists be able to charge the MBS for such case consultations.

When a patient is referred by a Doctor on a Mental Health Care Plan (MHCP), they are classified as having a mental health condition in order to be eligible for the MHCP. This 'diagnosis' is then on their medical record. However, there are times, that the medical doctor has not been able to offer the correct diagnosis. This could be for a number of reasons:

- The consult was not long enough to conduct a thorough assessment
- The doctor has limited training in mental health
- The patient has not yet established a therapeutic rapport to disclose all of the information necessary for the correct diagnosis

A psychologist, will usually offer at least 1-2 initial assessment sessions before a diagnosis is made. There are significant implications for a person's future insurance policies when diagnoses are on their medical records. Therefore, I recommend that measures are put in place to limit the possibility of false diagnoses to be placed on a patient's medical record prior to the consumer having even met with a mental health professional.

My understanding is that there have been prominent Psychiatrists sharing criticism of the Better Access Scheme. Whilst there are aspects of the scheme that need to be reviewed, I refute comments made that one risk of the scheme is that Psychologists might use methodologies that are not evidence-based, as long as Psychologists maintain their qualification. Psychologists abide by a strict code of ethics, it is in our training, whichever pathway has been taken, that we learn to apply evidence-based methodologies. It is by our engagement in continuous professional development (necessary to maintain our qualification) that we continue to evaluate and update our practices to be evidence-based.

I refute claims made that there are no review processes in place for private practising Psychologists when working within the Better Access Scheme. When a consumer is referred on a Mental Health Care Plan (MHCP) by a General Practitioner (G.P.), they are typically referred to a Psychologist known to that G.P. as offering evidence-based interventions. Typically, a relationship has already been established between the G.P. and the Psychologist by working collaboratively to care for a patient's mental health needs. The G.P. typically has some knowledge of what the Psychologist offers in terms of interventions, their specialities and prior successes of previous patients referred. A consumer is referred by the G.P. for 6 sessions initially on the MHCP, once those are used by the consumer, and more sessions are required, a is written by the Psychologist to the G.P. detailing the assessment, the treatment, progress made and recommendations for future management. The consumer must then schedule a review appointment with the G.P. and may be asked a series of questions to review the progress and engagement with the Psychologist in order to determine whether further sessions are approved. Psychologists typically use Outcome measure, the type depends on the client's presentation, as part of the reporting to the G.P. Outcome measures can include:

- DASS-21

- K10
- GAD-7
- PHQ-9
- SDQ
- DES-II etc.

Over the course of my career, I have often worked alongside, and liaised with Psychiatrists. However, I acknowledge my lack of capacity to comment on their practices as I do not know what review processes are in place for them. I do not know how often they have to report back to the G.P. Is it every 6th and then after every 10th sessions like a Psychologist has to? I do not know how many hours of continuous professional development they have to engage in every calendar year to maintain their qualification. I also do not know how they are held to review and accountability at applying evidence-based practises, and therefore I cannot comment. It therefore astounds me that prominent Psychiatrists seems to be commenting on the way Psychologists practice under the Better Access Scheme, and I can say with certainty that I have read and heard significant misrepresentations and misinformation about Psychologists. I implore the Commission to consider information about Psychologists from professionals/ organisations who are within that specific industry and not ignorant to the practice of a Psychologist.

Many thanks.