

SUBMISSION TO THE PRODUCTIVITY COMMISSION'S MENTAL HEALTH INQUIRY

Thank you for the opportunity to make a submission to the Productivity Commission's Mental Health Inquiry.

I am part-owner of and work as a Counselling Psychologist in a small, private, multidisciplinary clinic located in a regional centre in Victoria. Our team provides assessment, treatment and support services for children and adults with neurodevelopmental and/or mental health challenges. We receive no direct government funding or grants.

My submission is focused on the psychology profession and psychology services as integral parts of Australia's mental health services.

I bring to the Commissioners' attention the following:

1. Mental illness prevalence rates in Australia have not decreased despite increased mental health funding and services:

"Australia has had increasing resources allocated to mental health care, with an increased mental health workforce, increased use of antidepressants and, more recently, increased provision of psychological therapies, including e-therapy. However, there is no evidence for any reduction in prevalence of disorders or reduction in symptoms. If anything, trends are in the opposite direction." (Jorm et al, 2017).

In sharp contrast to this, evaluation of psychology services under the MBS Better Access showed significant improvements in the therapeutic outcomes, as indicated by significant reductions in self-reported symptoms, of consumers of psychology services (Perkis et al, 2011).

Psychiatrists' services were not similarly evaluated (Perkis et al, 2011) and their outcomes under Better Access remain unknown. This is of particular interest given the increased use of prescription medications for children as well as adults and the continued use of ECT in Australia, as well as the significantly higher Medicare rebates for psychiatry services, and recent calls by a few high-profile psychiatrists to not expand psychology services under the MBS Better Access initiative.

2. The dominance of mental health services by psychiatry is problematic as are prominent psychiatrists' conflicts of interest in the form of:

- funding from pharmaceutical companies
- shares and equity in companies (eg e-therapy technology).

Problems arise when these psychiatrists aggressively promote initiatives (eg e-therapy) they have equity in and/or continue to aggressively argue against the inclusion and/or expansion of other evidence-based services (eg psychology).

3. Much of recent government reforms (eg Primary Mental Health Networks, NDIS, headspace, e-therapies, etc) are based on the privatisation, outsourcing and/or sub-contracting of mental health clinicians and their services. This has had some unreported negative impact on segments of the mental health workforce.

As an example, headspace's average 'cost per occasion of service' was calculated as between \$210 - \$314. Their estimate for government investment via the headspace grant within the 2013/14 financial year was \$260 per 'occasion of service' (Hafekost et al, 2015). This 'cost per occasion of service' is significantly higher than the MBS rebates of \$84.80 and \$124.50 for psychology and clinical psychology consultations, respectively [see below].

And yet, headspace subcontracts many of its clinicians, including psychologists, and bulk bills under Medicare. This means that a sub-contracted psychologist will walk away with a portion of the \$84.80 bulk-billed to Medicare as their taxable personal income. If the consumer does not attend their appointment, then the sub-contracted psychologists earns \$0 for that hour. This is not sustainable by individual psychologists as these sub-contracting arrangements often result in reduced taxable personal incomes. Although

the consumer benefits from being bulk-billed and incurring no out-of-pocket-expense, the sole practitioner or subcontracted psychologists earn low incomes.

The situation is similar in the case of networks who also sub-contract many of their clinicians.

It is important for government to review the employment and/or subcontractor status of clinicians as service providers under government-funded initiatives and reforms. Government funding should enable organisations and networks to employ mental health clinicians, including psychologists.

4. It is very difficult to attract clinicians to regional areas without the offer of stable part-time (PT) or full-time (FT) employment. It is essential to recruit and employ qualified clinicians from metropolitan to regional and rural areas. Government incentives are required to achieve this.
5. Private clinics too are often unable to offer stable PT or FT employment without government support.
6. It is disconcerting that large government-funded organisations, networks and initiatives continue to subcontract many of their clinicians and draw them from the same pool of self-employed sole-traders that non-funded private clinics do.

In regional areas, all agencies and networks are drawing from the same pool of psychologists and other allied/mental health professionals. This pool can only increase if clinicians are recruited from metropolitan areas. In order to relocate, clinicians need the relative stability of PT and FT employment, not sub-contracting arrangements. To achieve this, government funding is needed specifically for the employment of psychologists and other clinicians, across all sectors, including private clinics.

7. E-therapy and tele-health are not the solution to rural mental health services. Rural and regional people too have the same rights to therapeutic relationships based on direct personal contact, as metropolitan residents do.
8. All psychologists in Australia have 'general' registration. Under national law in Australia, there is no specialist registration for psychologists only so-called Area of Practice Endorsements (AoPE). The Psychology Board of Australia (PBA) defines practice endorsement as follows: *"In Australia, all psychologists are registered on a single register which includes notation of area of practice endorsements. The notation of an endorsement is not a separate specialist register."*

The PBA defines nine AoPEs, clinical being one of them. The AoPE are not the equivalent of specialist registrations such as psychiatry in the medical profession. All registered psychologists, with or without AoPE, are fully trained, qualified and considered competent within the scope of their practice.

9. Psychology Board of Australia (PBA, 2018) figures indicate that in December 2018 there were 29,982 registered psychologists in Australia, of whom:
 - **71% (21,257) did not have clinical endorsement**
 - 61% (18,377) did not have any endorsements
 - **29% (8,725) had clinical endorsement**
 - 13% (3,919) had endorsements other than clinical.

The history of pathways to endorsements is highly controversial and is beyond the scope of this submission.

10. A situation has emerged in Australia where 71% (21,257) of registered psychologists are experiencing trade restrictions, infringements on the scope of their clinical practice and discrimination by awards, enterprise agreements, government guidelines and rebates that unduly differentiate between clinical psychologists and other registered psychologists.

Directly involved in this situation are the Australian Psychological Society (APS), the Australian Health Practitioner Regulation Agency (AHPRA), the Psychology Board of Australia (PBA), the Australian Psychology Accreditation Council (APAC), the Australian Clinical Psychology Association (ACPA), government agencies/departments (eg the

Department of Health, Medicare, Centrelink, etc) and various public mental health services.

11. Clinically endorsed psychologists have enjoyed various differentiations in their favour for over 12 years, since the inclusion of psychology services under the MBS in 2006.

The differentiation between 'psychologists' versus 'clinical psychologists' under Medicare has spread to other government and non-government organisations as well as other industries, including Centrelink, NDIS, awards and enterprise agreements.

12. To illustrate, please consider the following MBS Better Access initiative's differentiation between clinical psychologists v psychologists:

"The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative commenced on 1 November 2006. Under the Better Access initiative MBS items provide Medicare benefits for the following allied mental health services:

- *psychological therapy (items 80000 to 80021) - provided by eligible clinical psychologists; and*
- *focussed psychological strategies – allied mental health (items 80100 to 80171) - provided by eligible psychologists, occupational therapists and social workers."* (MBS, 2019).

Now, please consider the description of the following MBS item, delivered by registered psychologists with clinical endorsement:

*"Professional attendance for the purpose of providing psychological assessment and therapy for a mental disorder by a **clinical psychologist** registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting at least 50 minutes ...*

(Professional attendance at consulting rooms)

Fee: \$146.45 Benefit: 85% = \$124.50 " (MBS, 2019).

In contrast, please now consider the corresponding MBS item for registered psychologists who are equally qualified and competent in delivering psychology services within the scope of their practice:

*"Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a **psychologist** registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 50 minutes ...*

(Professional attendance at consulting rooms)

Fee: \$99.75 Benefit: 85% = \$84.80" (MBS, 2019).

13. The significantly higher Medicare rebates receivable by the clients of clinical psychologists (ie \$124.50 versus the lower rate of \$84.80) continues to discriminate between consumers. Clients of 'general' (sic) psychologists continue to face larger out-of-pocket expenses than the clients of 'clinical' psychologists who may be delivering the same psychology services (eg cognitive behavioural therapy).

14. The so-called 'focused psychological strategies' are an artificial and bureaucratic term. They are currently specified and effectively restricted to the following:

1. Psycho-education

(including motivational interviewing)

2. Cognitive-behavioural therapy including:

• **Behavioural interventions**

- Behaviour modification

- Exposure techniques

- Activity scheduling

• **Cognitive interventions**

- Cognitive therapy

3. Relaxation strategies

- Progressive muscle relaxation

- Controlled breathing

4. Skills training

- Problem solving skills and training

- Anger management

- Social skills training

- *Communication training*
- *Stress management*
- *Parent management training*

5. **Interpersonal therapy** (especially for depression)

6. **Narrative therapy** (for Aboriginal and Torres Strait Islander people)" (MBS, 2019).

This is a restrictive list which excludes many evidence-based therapies.

15. Currently under Medicare, registered psychologists without clinical endorsement continue to be not allowed to practise evidence-based 'psychological therapies' outside of or beyond the restrictive list of 'focussed psychological strategies', even if they are trained, qualified and competent to do so. This means that the majority of registered psychologists continue to be restricted by Medicare from practising within the true scope of their evidence-based practice.

16. During 2007-2009, most Medicare Better Access services were provided by GPs and 'general' (sic) psychologists:

"In each year, the vast majority of Better Access consumers (more than 85%) received at least one Better Access service from a GP. This is consistent with the functions of the GP mental health treatment plan and review item numbers (2710b and 2713, respectively) as gateways to further Better Access services. Focussed Psychological Strategies services provided by general psychologists had the next highest uptake rate; just under one third of Better Access consumers received one or more of these services in each year. These were followed by uptake rates for Psychological Therapies services provided by clinical psychologists, then Consultant Psychiatrist services" (Pirkis et al, 2011).

There were significant improvements in outcomes following treatment by both 'general' (sic) and 'clinical' psychologists (Perkis et al, 2011). This was evidence that the 'general' versus 'clinical' differentiation was artificial, not evidence-based and therefore discriminatory to both psychologists and their clients.

17. Registered psychologists are trained, qualified and competent to practise and deliver psychological assessment and therapy services within the scope of their practice. Single tier rebates and awards must apply to registered psychologists regardless of area of practice endorsements.

The APS, AHPRA, PBA and Medicare have jointly contributed to the restriction of the practice of up to 71% (21,257) of Australia's registered psychologists as this differentiation has spread across sectors, to the extent that some agencies (eg Centrelink) are not accepting assessment reports from registered psychologists other than clinical. Consumers suffer from these restrictions on their service providers.

18. The MBS Review is currently under way and it is hoped that this restrictive and discriminatory situation will be corrected by the replacement of the current 2-tier Better Access rebates with new single-tier rebates. The Mental Health Reference Group's Report seems to be a step in the right direction.

19. Governments need to be aware that the adverse effects of these past 12 years have spilt from Medicare to other jurisdictions, as mentioned above. It may require review and action by governments to ensure that all 29,983 registered psychologists can work according to their training, qualifications and competencies, within the scope of their practice, in all sectors, without undue restrictions and without discrimination.

It is ultimately in consumers' interest to have direct access to the entire psychology workforce and for this access to be funded and subsidised by governments in a manner that is fair and equitable.

This situation needs urgent review by government because it continues to impact the current and future configuration and clinical capacity of Australia's existing and future psychology workforce.

20. It is of concern that in their recent submission to the MBS Review's Mental Health Reference Group, the APS recommended continued and further differentiations between registered psychologists on the basis of their areas of endorsement (APS, 2018).

Psychology seems to be the only profession where this discriminatory situation exists and the APS seems to be the only professional body to consistently promote such differentiation and discrimination amongst its own members.

Governments need to be aware that significant numbers of psychologists are leaving the APS and joining another, emerging professional body, the Australian Association of Psychologists Incorporated (AAPI) who do not support differentiation based on AoPE within the profession of psychology.

21. In the profession of psychology the roles and inter-relationships of the APS, AHPRA, PBA and APAC need to be reviewed by an independent body in light of the continued and increasing restrictions imposed on registered psychologists. Most office bearers of these agencies are Clinical Psychologists. Office bearers of these agencies must be representative of the entire psychology workforce.

I recommend that:

1. governments review employment and sub-contracting arrangements by organisations and networks in receipt of government grants and funds
2. the 'costs per occasions of service' of government-funded networks, organisations and incentives are directly compared
3. governments provide incentives and funding for the employment and relocation of mental health clinicians, psychologists included, from metropolitan to rural areas
4. governments provide funds and grants for the employment of mental health clinicians, psychologists included, in private clinics
5. governments ensure that rebates, awards and enterprise agreements do not discriminate between registered psychologists on the basis of 'area of practice endorsements' and/or the lack of such endorsements - which are problematic, not the same as nor the equivalent of specialist registration and have been subject to concerns and inquiries outside the scope of this submission
6. governments review trade restrictions and infringements on the employment, classifications and clinical practice of registered psychologists performing clinical work in mental health
7. governments investigate and enforce the independence of professional and regulatory bodies such as the APS, AHPRA, APAC and registration boards including the PBA. Members of the boards of these organisations must be truly representative of the professional cohorts that they represent and/or regulate. For example, members of the PBA must be representative of all registered psychologist, including those without endorsement as well as all 9 areas of endorsement.
8. governments review psychiatry's dominance over the mental health sector and no longer invite, encourage or rely on a few prominent psychiatrists to speak on behalf of other mental health professions and/or services, psychology included
9. governments stop seeking and relying on the advice of a select few high profile individuals whose conflicts of interest have not been declared, identified and/or acknowledged as potentially problematic
10. individuals with significant conflicts of interest be excluded from advisory and decision making positions and roles in the mental health sector.

Thank you for your consideration of the above.

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12/4/2019

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