



SUBMISSION TO THE PRODUCTIVITY COMMISSION INQUIRY INTO
THE ROLE OF IMPROVING MENTAL HEALTH TO SUPPORT
ECONOMIC PARTICIPATION, ENHANCE PRODUCTIVITY AND
ECONOMIC GROWTH

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Background

Psychology CAFFE (Psychology Child Adolescent Family Friendly Environment)

- Psychology CAFFE was established in 2011 in response to a community need for a child and family mental health practice which would provide mental health services for children under 12 years and their families. Initially the practice opened one stand-alone office with 6 consult rooms in Latrobe, a rural town in country Tasmania. The practice was offering individual, family and couple sessions and parent groups on attachment parenting, with children's groups on life-skill development to address self-esteem issues in children under 12 years.
- Psychology Caffe is now a large multi-disciplinary group private practice, uniquely servicing a remote and rural area of around 15 000 square km across 9 locations. The practice is registered with the NDIS, has PHN contracts, and provides third party, MBS and insurance consultations. 11% of clients accessing PHN short term psychological intervention (STPI) funding identify as Aboriginal, or Torres Strait Islander (ATSI) (who are 3% of the population in our region) approx. 50% of clients are children, and 60% of referred clients have moderate or severe MH presentations, including children and young people.
- Psychology CAFFE provides supervision and training for mental health and other professionals, medical and psychology students, Peer Support Officers (PSO's) for Ambulance Tasmania and prioritises primary consultations for first responders and other health professionals.
- Psychology CAFFE has grown and expanded in 2018-2019 delivering over 5000 individual sessions, and four group programmes (8-12 participants) to parents and carers of children and young people, both on site, and co-delivered in schools to early childhood settings.
- The practice provides education and training for other services, including government services, including Sexual Assault Services, CAMHS, the Education Department and psycho-social service providers, hosts workshop for professionals and developed and delivers group trainings in the community for parents and carers.
- Psychology CAFFE contributes to workforce development, hosting university master's students, in psychology, social work, and medicine through UTAS. Is an organisational member of the Mental Health Council of Tasmania (MHCT) and contributes and co-facilitates community events and MHPN forums.
- Psychology CAFFE is **co-located with other services in six locations** (Deloraine, Sheffield, Devonport, Smithton, West Coast and Burnie) and have standalone **health**

centres in Latrobe and Ulverstone in central locations with easy transport and access to schools and medical centres.

- **Psychology CAFFE is a multi-disciplinary team of mental health (MH) clinicians** – 16 individuals with tertiary mental health postgraduate degrees and additional training and supervision to meet the AHPRA and AASW requirements for mental health accreditation. The team consists of Psychologists (8), MH Social workers (6), MH Occupational Therapist (1) and a MH Nurse (1), and in our most central office we are co-located with a Psychiatrist, and a Speech Therapist.

Psychology CAFFE is based on the Northwest and West Coast of Tasmania – an area with the highest unemployment, lowest level of education, and high rates of intergenerational trauma and abuse, and higher rates of suicide.

We have a higher percentage of children per capita than the rest of the state, with bigger families with lower socio-economic status. Higher hospitalisation rates for Mental illness than the rest of the state, and higher rates of severity of mental illness, behavioural disorders, and acute suicidality in the community sector than the rest of the state. (see article from 2016 written by the author with associated statistics).

The statistics in our area can be somewhat attributed to geographic dislocation, historical shortages in funding and services leading to increased severity and crisis levels of MH presentations and consequently, leading to increased demand and severity in the community sector.

Challenges in our community for delivery of mental health services

1. Poor efficiencies with **funding cycles** impact workforce development and limit services:
 - Recruitment – creative and persistent networking and recruitment are essential to build a good reputation and develop a strong clinical base,
 - In 9 years of experience in community based mental health intervention, we have learned that demand will not change whilst funding is reactionary and inadequate. Thus, the practice has developed its own recruitment and training programmes to facilitate clinical team and to ensure good governance, with financial assistance through incentive programmes such as government funded, HR recruitment Plus.
 - Regular review and improvement of policies, structures and processes has supported an increased focus on team culture, training and development, along with automation of systems and procedures to support consistent and efficient onboarding and training for clinical service delivery.
 - All this investment is expensive and with the shortage in our rural area, we have to offer very high salaries and benefits to attract suitably credentialed clinicians, it is not true that we have enough clinical professionals, AND we have to utilise their skills more effectively, in addition to one on one clinical work, they need to be building capacity in our communities.

- ***Retention*** – We have a strong focus on prevention in our own team due to pressure from constant high demand, severity and complexity which can lead to high rates of burnout and vicarious trauma or re-traumatisation.
 - Psychology CAFFE provides weekly group and individual clinical supervision, regular training and whole team planning and CPD days, including burnout prevention. The business invests heavily in the team, in both clinical and administrative areas to provide excellence and a client centred approach, our retention is good, AND our clinical outcomes are very good.
 - Data over the past several years from PHN funded clinical work is in the NMHC-MDS and needs analysis to assess how clinical skills can lead to outcomes that are beneficial and positive, along with analysis of how to be more effective utilising those skills to build capacity in the communities where they are most needed.
 - The practice maintains practice systems and software and employs consultants to ensure quality and healthy workflow to maximise productivity and workplace health.

2. **Integration of the state and federal MH funded systems**

On the ground the communication and working together of these systems seems to be getting better, however, whole system integration is required to develop pathways for clients following the commissioning of federal mental health services over 3 years ago. This would help to close service gaps and increase efficiencies.

The whole team and our community have concerns about frequent restructuring or re-commissioning and the impact this would have on clients, families, children and existing service providers grappling with regular systemic change and its impact on good quality service delivery.

There is also value in turning systems on their heads, and a solid review of MHS is important – we are desperately in need of service hubs for early interventions and supports, for 5-12-year-old children and families, who are the biggest gap in our community. This would reduce the demand on overstretched state-wide mental health services. Utilising community based and experienced expert clinical knowledge to inform and coach families and strengthen community health is so essential for long term growth and development.

3. **HUBS or family centres that are funded to support families of 5yrs -12yrs children – DO NOT EXIST - THIS IS THE SINGLE MOST USEFUL ADVANCE** that could prevent the escalation that occurs from 12-18 years of age in homelessness, suicide and increased chronic and severe MH presentations. It is well documented that children’s emotional and behavioural symptoms are precursors to later mental health problems which impact on their education and ability to contribute productively and economically to our community in their later years.
4. **Emotional and behavioural problems in children between 5-12 years of age**, is regularly highlighted as a substantial burden on our health care systems in paediatric

primary care settings, in GP clinics and our education settings. Our education system needs our children to be attentive and settled to learn. Teaching is impacted severely by management of children with emotional and behavioural difficulties in the classroom, and attendance records in schools show absences due to these issues that impact on their ability to learn and be educated.

5. **Prevention and Early Intervention** – We don't have centres that support families with AT RISK children between 5-12 years of age.
 - Primary Schools, Paediatricians, and General Practitioners are reporting despair and concern about families presenting daily with children who have emotional and behavioural problems created by disconnection, and dysregulation in our 5-12 years old children. Early markers if not identified and resolved, lead to moderate and severe mental health presentations prior to 18 years of age. Most commonly in children 13-18 years – the primary age of first diagnosis of severe MH problems.
6. **Psychology as a profession** is experiencing a significant shortage with nationwide recruitment issues, and the profession has been fractured and tarnished by a lack of advocacy and understanding of the diversity of the profession and the high level of training required for registration to practice as a clinician. Registration does not equal endorsement, and licencing of psychologists in the USA, is similar to registration here, and NOT the same as the Australian 'Area of Practice Endorsement' (AOPE) which is simply an extrapolation from membership of interest groups of the APS prior to 2010. Approximately half of the psychologists in Australia with AOPE did not complete a postgraduate training, rather they applied for a recognition of prior learning (RPL) assessment – otherwise known as a grandfathering process. Training pathways have been subsequently challenged and changed PRIOR to a need's analysis being undertaken based on research into clinical outcomes of psychologists trained through different pathways. This is a major issue for registered psychologists with up to 10 years of registered clinical practice without AOPE – and will present a HUGE challenge to the workforce unless an RPL process is applied for ALL eligible psychologists registered between 2009 and 2020, and prior to any irrevocable changes to service delivery, including Medicare registration or community access.
 - Why is this an issue for the productivity commission to consider?? 75% of rural remote psychologists are generally registered psychologists – who are not endorsed in an area of 'practice' other than general clinical practice, and they are equally able to provide clinical assessment, diagnosis and clinical treatment of all presentations where suitably trained, including clients with severe and complex mental illness.
 - Under current MBS referrals, a client seeing a generally registered psychologist has a 40% lower MBS rebate than a clinically endorsed psychologist, resulting in a higher gap fee for rural/remote clients, making access for these clients problematic or impossible. Of concern, is the proposal for a 'new' model with three tiers that doesn't include a flat rebate for mental health care. This model does not allow for equitable consumer choice, rather it promotes elitist mental health care for wealthy consumers from AOPE psychologists only.

- Research indicates that generalist mental health professionals can provide equal or better care when compared to the clinical psychologists. (PIRKIS, 2005)

Ten years post the APS driven AOPE process and NO subsequent recognition of prior learning (RPL) process has been established for any psychologists registered via the 4+2 pathway between 2009 and 2019. In addition, postgraduate pathways to AOPE are not available in rural remote areas (despite adequate technology) this is a challenge for psychologists such as myself, who live and work in a rural remote area, delivering much needed education, training and clinical intervention to not only clients, but other professionals to upskill our communities with mental health. My personal example follows:

I registered in 2008 under the 4 + 2 pathway, and completed a comprehensive internship in mental health services, I was supervised for 3 years by a clinical master's graduate in psychology and had additional fortnightly supervision with a child and adolescent psychiatrist. In addition, I completed two postgraduate certificates via distance and block release during that internship specific to mental health diagnosis assessment and treatment. I was ineligible to transition under the grandfathering due to the timing of my full registration being granted on the cusp of the change. Subsequent to registration, I worked in a clinical setting for a further 10 years, in 2018 I was approved by the Psychology Board of Australia (PBA) as a supervisor, as I was considered to have substantial clinical experience and thus am eligible to supervise clinical master's graduates FOR endorsement, though I myself am not eligible for endorsement.

The profession urgently needs an independent review of changes driven by a desire to provide an elite status for clinical psychologists, at the expense of consumer choice, and access to suitably trained professionals who have equivalent training and clinical supervision but are prevented from applying for AOPE. This has created a situation where inadequate variety and access to postgraduate training, and remuneration has resulted in a depletion of expertise in our regional communities. The recommendations by our own professional body, results in the consumer not being able to obtain a rebate for their treatment, unless they see a clinical psychologist, when clinicians with other AOPE and other MH professionals are more suitable for their needs.

The lack of RPL for psychologists working in a clinical setting will (and does already) restrict their practice, due to this oversight during the past decade. If the APS proposed changes to a 3-tiered system are approved under the current Medicare Review there will be a massive gap in service delivery for community based mental health, in both rural and urban areas.

7. Rural Remote Challenges to health and their impact on education, jobs and wealth – Higher rates of suicide and their impact on rural communities.

Psychology CAFFE has data that indicates that up to 40% of presenting adults in our community across 15 000km of rural remote Australia, report suicidal ideation, and of these 15% report suicidal intent. Most of these clients have not reported this to the referring GP or health practitioner, primarily due to limited time to develop rapport, or a GP that is unfamiliar with how to ask the correct questions and unpack the context leading to disclosure of suicidal ideation and intent. This is in turn not reported in the national PMHC-MDS as it isn't listed on the Mental Health Care Plan (MHCP) provided by the GP and therefore is a skewed statistic that leads to gaps in the system.

Approximately 10% of general practitioners have identified suicidality in the referred patient, the referral information is relatively brief, and the GP is not required to provide a full history to the mental health practitioner, this represents 30% of referred patients who are considering attempting suicide NOT captured in our data to better target intervention. In addition, there is frequently a double up (in \$ and time) in the assessment process due to inadequate history taking or provision of the same from the referring practitioner to the treating clinician who then spends additional time completing a thorough assessment to inform intervention.

Tertiary trained mental health clinicians spend on average 6-8 years of full-time training in bio-psycho-social assessment of referred clients across the lifespan, including a comprehensive semi-structured interview, and psychometrics to assist with diagnosis. It takes a specific skill set to build a thorough assessment that will elicit the full picture, medical practitioners in a health setting, have relatively minimal training in mental health and always have limited time and access in rural remote communities. The opportunity to build knowledge and skills in the community to reduce demand on GP's and on community mental health services, is an untapped potential that could have exponential impact on the health and wellbeing and thus productivity of our communities. By targeting earlier education and intervention delivered by highly skilled professionals, along with the middle tier interventions and primary mental health care, we can truly make a quantitative difference.

Redesign of our approach to mental health and our wellbeing

The National Mental Health Commission Report (2018) highlighted the need for evidence of the benefits of early intervention and prevention, including economic, however, we do not have programmes and key projects in our community to evaluate, particularly between 5-12 years of age. This is the most crucial age for families with huge challenges in our children's emotional and behavioural presentations, impacting our schools, and our communities. Lack of attention to this area, results in a massive burden on our general practitioners, paediatric clinics, and CAMHS services, resulting in increased adolescent mental illness, and later suicide rates, impacting our families and communities.

Change is desperately needed, and Psychology CAFFE has found we have organically grown to be a unique community-based family hub for children from 3-15 years of age. To better manage the demand for our services, we have developed groups and parent training, but have limited resources to evaluate our projects. See this article for a summary on how a radical re-

design can work. We have been grateful for the opportunity to co-design with our PHN, in a manner like the one outlined in this article:

The Adverse Childhood Experiences evidence base-a wakeup call to radically re-design Children's Mental Health Services. Retrieved from:

<https://weneedtotalkaboutchildrensmentalhealth.wordpress.com/2017/10/30/the-adverse-childhood-experiences-evidence-base-a-wake-up-call-to-radically-re-design-childrens-mental-health-services/>

Our state government held a state-wide forum on youth mental health in 2019, where the need for reform was reiterated, and the response to the state government taskforce outlines support for the reform of our state and federal funded programmes.

https://www.dhhs.tas.gov.au/_data/assets/pdf_file/0008/378332/MINUTE_-_Attachment_02_-_Gover_rce_Report_and_Recommendations.pdf

8. **Solutions:** Interventions and investment need to be delivered concurrently in primary and tertiary settings for long term gains.

- Increased Funding to facilitate **early intervention and prevention** in the form of groups and parent training on attachment and child social/emotional development conjunction with MH professionals and within primary schools and
- Peer leadership and MH skills-based groups for high schools and for ALL families at ALL stages of development.
- **Increased funding and number of sessions for individual treatment** for those with moderate and severe mental health presentations – with choice of MH professional with linkages, to multidisciplinary HUBS that are integrated and skilled with access to appropriate services, including housing and MH supports. Lack of improvement in MH outcomes is because of inadequate expenditure on MH over the past decade, and the evidence supports an increase acuity and complexity (thus increased expense) over time. This combined with increased help seeking due to reduced stigma, leading to increased demand, results in increased wait times and a need for more creative ways to build health in the individual, the family and the community through pathways and integration on the ground.
- Highly skilled and trained administrative and clinical teams to create the community based Hub for individuals across the lifespan, particularly the **HUB model for families with 5-12 year old children**, with a model (like Trieste) that focuses on interpersonal relations and creating a community focus that *reduces* stigma, isolation and *increased* health and access to and understanding of how work and play builds healthy communities. This would significantly reduce the burden on our communities in the long run, for families and young people at risk of developing lifelong psychiatric diagnoses

receive timely and appropriate intervention much earlier than they currently do.

- **Improved pathways and integration of services**, with up to date local service databases that link services in a true stepped care model to eliminates gaps. See Health Pathways - <https://www.primaryhealthtas.com.au/for-health-professionals/tasmanian-healthpathways/> - this along with whole service support and access – along with documentation of the pathways between services, particularly state and federal.
- **Housing supports** for young people at risk of homelessness, beyond crisis housing and early enough (even before child safety is required) so they can have stability and engage in education.
- **Intensive Early Intervention Centres** for high risk families involved with the child safety system in our regional areas. High intensity services like **NewPIN** (New Parent Infant Networks) – that provide highly skilled evidence-based supports that assist families with children under 6 years. 60% of the families involved with the child safety system, can stabilise with the right intervention at the right time. 15% of the families create 60% of the notifications, adoption and tighter assessments would resolve this (Sammut, 2015). We need more intensive intervention, and earlier, to avoid the escalation in adolescent and adult mental illness that can be avoided in the first place.

In other countries around the world, South Africa, Germany, Canada, United Kingdom and USA psychologists are required to complete 50hrs of personal therapy as part of their licencing (registration) and training, this results in more effective work with clients on a social neurobiological level. In Australia this is not a requirement for registration or training as a psychologist or clinical psychologist, and an external review into our training pathways including suitability for practice, evidence of competency, and RPL for clinicians in clinical practice more than 5-10 years, along with research on outcomes across professions, would assist in determining economic and clinical effectiveness of mental health funds.

Unfortunately, our mental health professionals who have experience of working clinically in our communities are not academics nor are they working in a context which affords a voice at state or federal level, and thus, the experience on the ground is rarely voiced at a level that can guide development of the profession.

Thank you for the opportunity to present to the commission in Launceston, Tasmania, and for accepting the comments enclosed, it is a somewhat amateur approach, given the limitations inherent when so busy on the ground, and not having access the latest publications to back up observations and experience. I can anecdotally support the finding in the Pirkis et.al. (2011) study, that the clinical training is not necessarily the variable that results in good therapeutic outcomes, it is the social neurobiological interaction with a trained therapist, in the right way, and in the right place at the right time, that is the core of the therapeutic outcome. In my opinion the profession could advance in a more productive and holistic way if it kept this in mind and restructured on many levels.

Government Response to The Mental Health Integration Taskforce Report and Recommendations (July 2019) Department of Health, Tasmania.

[https://www.dhhs.tas.gov.au/_data/assets/pdf_file/0008/378332/MINUTE - Attachment 02 - Governance Report and Recommendations.pdf](https://www.dhhs.tas.gov.au/_data/assets/pdf_file/0008/378332/MINUTE_-_Attachment_02_-_Governance_Report_and_Recommendations.pdf)

National Mental Health Commission. Monitoring Mental Health and Suicide Prevention Reform: National Report 2018.

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Pirkis, J. Harris, M. Hall, W. Ftanou, M. (2011). *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative*. Final Report.

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