

April 2019

Australian Productivity Commission

Inquiry into Mental Health

Dear Commissioners,

Thank you for inviting responses to The Government's inquiry into Mental Health Services within the Australian Community. As the majority of specified areas of inquiry within this process have been widely spoken to in great depth, by a number of my colleagues, I will take this opportunity to speak to some of the more practical considerations for the Government to consider in relation to the needs of all Psychologists generally, which will enable them to continue to serve the communities across Australia with the breadth and depth of the diversity of skills which they bring.

Personally, I speak from the awareness which my professional experiences and community involvement has given me, across many business, organisational structures and health care settings in clinical private practice and working across three (3) different states of Australia, over the last 22 years.

I speak to the reality that if these issues remain unaddressed, the impact of the unintended consequences will be dire for the wider Australian population, and specifically to the poor and rural and remote community members in our midst.

I suggest that the first measure taken is in assessing the causes of diagnosable mental illness rather than simply treating the symptoms.

1. Conduct an overall assessment of exposure to trauma in the community and its impact on the development of long-term physical and mental health disorders.

In 1997, the Center for Disease Control and Prevention surveyed the incidence of childhood traumatic experiences (Adverse Childhood Experiences Study - American Journal of Preventative Medicine) of 17,000 middle-class adults in the USA. They were each asked 10 questions relating to abuse, neglect, family violence and household distress. Almost two-thirds of the adults reported at least one adverse childhood experience (ACE), and 12 % had four or more ACES. Researchers correlated the number of ACES with health outcomes and found that

Adults who had experienced 4 or more ACES before the age of 18 were:

- 12 times more likely to attempt suicide;
- 4 times more likely to experience depression;
- 2 times at risk of developing cancer; and
- Likely to have their lifespan shortened by 20 years.

The World Health Organisation (WHO) has replicated the study internationally and subsequent studies support the view that maltreatment and household distress in childhood contributes to health problems decades later. The Australian Institute of Family Studies notes, "Australia is one of the only developed countries where there has been no methodologically rigorous,

nationwide study of the prevalence or incidence of child abuse and neglect". (CFCA Resource Sheet - April 2017.)

It is only relatively recently, that the psychiatric community has officially recognised that children exposed to trauma develop the symptoms of PTSD (DSM5 2013), which continue into adulthood.

2. Funding Evaluation of Mental Health Programs

The government continues to prioritise mental health funding and respectfully allocates between \$4-9 billion in funding to various mental health programs each year. However these programs remain inconsistent and unevaluated, and also concerningly: apparently "dependent". That is that those who choose to "evaluate" their programs, do so with self-developed tools of inquiry, some could argue, that they find what they are looking for, rather than a true reflection of the actual outcomes, and fail to adequately provide any credible accountability and therefore necessarily leave themselves open to these criticisms, whether warranted or not.

I propose that an independent inquiry into the funding of mental health and the outcomes which these budgets is established in order to provide clear and transparent reporting structure, consistent over time, which can be reported back, in plain English, to the Australian tax-paying public.

3. Investigation into who are Advising Government and our communities?

I call on The Government to investigate the composition of the Psychology Boards of Psychology across Australian, to ensure that all Psychologists are proportionally, equally and suitably represented.

4. Medicare: Anchoring of Disparity- False Narratives and Artificial Divisions

The introduction of the Medicare Better Access to Mental Health Care scheme in November of 2006 has proven to be a critically important initiative, providing over 30 million individual treatment services for Australians and their families with mental health disorders since its inception.

The two-tiered system of Medicare rebates for psychology services has cost Australian taxpayers millions of dollars already and increasing costs may threaten the future viability of the Better Access scheme. The discrepancy in the allocation of public funding has had three unwarranted inequity effects:

1. Marked inequity in Medicare funding allocated to members of the public via inaccurately assigned severity ratings according to type of psychologist seen;
2. Marked inequity of access to Medicare funded psychological services by members of the public accessing psychological treatment through Better Access;

3. Marked inequity in the number of psychology graduates entering the other eight endorsed areas of psychology, and number of clinical psychology programs offered at tertiary institutions across Australia.

Australians need a wide range of psychologists, now and in the future. The two-tiered model has set the precedent for many government programs to follow Medicare's system and pay psychologists significantly less than their clinical colleagues (e.g. Department of Veterans Affairs). Over the last decade, significant misinformation has been provided to government and professional bodies such as Medicare, WorkCover, DVA, NDIS, falsely claiming the superiority of clinical psychologists over other psychologists (for example, the multiple submissions made by the Australian Clinical Psychology Association and submissions by the Australian Psychological Society to varied organisations). The result of these non-evidence based assertions and misinformation has led to the development of the two-tier Medicare rebate system, two-tier DVA and most recently a proposed two-tier NDIS system, ensuring that clinical psychology services receive significantly higher rebates than all other psychology services, for no "better" treatment outcomes.

Currently, under the Medicare Better Access program, clients of clinical psychologists are rebated \$124.50 per 50-minute session. Clients of all other psychologists (even those psychologists endorsed in other areas) receive \$84.80 rebate for the same length session. However, both general and clinical psychologists see similar clients with similar presentations. In cases where psychologists bulk bill services, these psychologists are therefore paid significantly less than clinical psychologists for treating the same type of clientele. If any other allied health profession or industry paid their professionals almost 50% more for doing the same job with similar levels of complexity and responsibility, there would be industrial action and public outrage.

What is a 'generalist' or 'registered' psychologist?

All registered psychologists are trained in and can diagnose, assess and treat clients, regardless of whether they are clinically endorsed or not.

Some psychologists choose to apply for endorsement in a particular area. Many of these endorsement areas are relevant to servicing a wide range of mental health consumers under the Medicare Better Access program. In Australia, we have nine areas of endorsement but only clinical endorsement attracts the higher rebate. Registered psychologists represent by far the majority of the Australian psychology workforce. In September 2016 there were 27,791 (79%) registered psychologists (incl. 3,725 other endorsed) compared to 7,620 (21%) clinical psychologists (AHPRA: 2016).

Relevantly, the Psychology Board of Australia (PsyBA) via its parent body the Australian Health Practitioner Regulation Agency (AHPRA) presently offers endorsements in areas of practice and other equally valid and effective pathways to registration. All psychologists experience advanced training with supervised practice. Further, all registered psychologists are required to undertake Continuous Professional Development (CPD) that is relevant to the scope of their practice.

Beyond the notion of Area of Practice Endorsement obtained via a more pedagogical educational process involving university masters courses, there is currently a supervised practice pathway to registration in Australia. This captures and effectively utilises more of the diversity available among students and thereby increases the overall validity of the training process. One reason for this is that some students are more aware of and more specifically targeted in their learning needs than others. Such students are more appreciative of training systems where they can experience far more situated practice combined with a genuine

reflective action research oriented approach in which they can begin to develop their own practice.

Do clinical psychologists have additional training and expertise compared to other all other psychologists?

The Australian Clinical Psychology Association's Dr Judy Hyde stated in 2015 that 'more than half of those clinical psychologists currently endorsed by the Psychology Board of Australia do not have qualifications in clinical psychology, although these are now required for endorsement going forward.' When the registration system for psychologists moved from the state-based systems to being federally managed by AHPRA, many members of the APS were endorsed in areas of their choosing. Therefore, many clinical psychologists hold the same level of training and qualifications as generalist or registered psychologists. Qualified registered psychologists hold at least a four-year accredited undergraduate degree majoring in the science of psychology, plus at least a two-year supervised practice component. Large portions of generalist psychologists hold postgraduate psychology qualifications such as Masters, doctorates (our research indicates 65% of generalists Psychologists). Many also have undertaken specific training in particular techniques such as EMDR, a WHO Gold Standard treatment protocol for PTSD. Some choose to become endorsed in their college, but many do not. Psychologists cannot be considered better trained or skilled by virtue of holding the title clinical psychologist or any other endorsed area. The quality, skills and knowledge of a psychologist cannot be deemed by endorsement status alone, nor are all clinical psychologists necessarily better trained.

There are three key reasons why all psychologists have equivalence in practice expertise:

1. All psychology pathways to registration and practice are subjected to rigorous development and stringent monitoring to ensure the same baseline competencies are upheld;
2. Expert clinical practice involves a complex mix of practice experience, supervision and professional development as key variables in treatment outcomes – beyond academic qualifications; and
3. Yearly registration ensures all psychologists have extensive formal requirements across practice experience, supervision and professional development to ensure practice expertise continues to build post-graduation.

Unlike specialities in medicine, the notion of clinical practice in psychology is not unique to clinical psychologists. Psychologists who have gained registration from many different training pathways are engaged in clinical practice every day in Australia, treating people across a very broad range of conditions and levels of severity. The skills to diagnose, treat mental illness therapeutically, and produce effective outcomes are not unique to one area of psychology. Once again, the scientific evidence highlights this. Importantly, there are a number of different pathways to registration to practice as a psychologist in Australia. Psychologists, participating in and completing these pathways, all experience advanced levels of training and supervised practice. All psychologists are required to complete Continuous Professional Development that is relevant to the scope of their practice and interests.

A notable research project commissioned by the Australian Government (Pirkis et al, 2011) incidentally provided evidence of equivalency among psychologists. Psychologists treating mental illness across both tiers of Medicare Better Access produced equivalently strong

treatment outcomes (as measured by the K10 and DASS pre-post treatment) for mild, moderate and severe cases of mental illness.

There was no observed difference in treatment outcomes when comparing clinical psychologists treating under tier one of Medicare Better Access with the treatment outcomes of all other registered psychologists treating under tier two of Medicare Better Access.

Do clinical psychologists see clients with higher complexity or severity of mental illness?

Many psychologist colleagues and I have worked in mixed practices and found that clinical and non-clinically endorsed psychologists see very similar clients. Psychologists generally see clients based on their areas of interest and training, such as working with children or clients experiencing specific mental health conditions, clients with intellectual/developmental disability or certain health conditions.

Far from focusing on those high-intensity patients, the caseload of endorsed clinical psychologists in private practice closely resembles that of their lower paid colleagues in clinical practice who are, according to all available evidence, achieving the same or better outcomes.

Should there be two categories for psychological therapy?

There are two different categories for therapy under the Better Access program: Focussed Psychological Strategies (which covers what non-clinical psychologists can use with their clients, however OTs, GPs and Social Workers can also use these strategies); and Psychological therapy services (clinical psychologists only).

Fully registered and qualified psychologists should not be restricted to deliver the same services as other allied-health professionals who are not specifically trained in psychology. Every psychology degree includes a number of units of counselling and therapy and all psychologists are required to deliver interventions under supervision during their 4+2 / 5+1 internships or masters/doctoral programs. All psychologists completing their internships via these pathways must demonstrate competency in eight core areas of clinical practice, including ethical, legal and professional matters, psychological assessment and measurement and intervention strategies.

Focussed Psychological Strategies dictates a restrictive set of psychological techniques (See Appendix A). All psychologists are educated and trained in the main therapeutic approaches of psychology and psychotherapy. However, many of us have completed further non-university based study in areas such as Acceptance and Commitment Therapy, Schema Therapy, Trauma-Focussed Therapies, Narrative Therapy etc. *If psychologists have completed further training in these areas and feel competent in their delivery, shouldn't they be able to use the evidence-based approach that is most suited to the client?* For example, Eye Movement Desensitization and Reprocessing (EMDR) requires therapists to be certified by the international EMDR Institute and is now considered an evidence-based practice. This certified training is not part of any clinical masters program and psychologists outlay thousands of dollar to be certified. Similarly, many non-clinically endorsed psychologists are advanced trained in ACT or Schema Therapy. However, due to the restrictions placed on the FPS, these therapies cannot be used with Medicare clients.

Inversely, there are no restrictions placed on clinical psychologists under the 'psychological therapy services' category. If these arbitrary restrictions must continue, the FPS strategies needs to be updated in light of new research on evidence-based practices.

Does a higher rebate equal increased access to psychological services?

The justification for the two-tier system – that it would allow patients cheaper access to “specialist” psychologists with improved treatment outcomes has not happened, despite over ten years of operation. Nor has it led to endorsed clinical psychologists treating more serious mental health conditions than non-endorsed psychologists in clinical practice – a major point made by the original advocates for the two-tier system. Likewise, Harrison and colleagues found that uptake for Better Access services was highest in advantaged urban areas rather than being spread fairly across the country. This is likely due to concentrations of clinical psychologists in urban locations. Accessing clinical psychologists has recently been shown to be unfairly distributed, with the richest segment of society has over double the use rate for clinical psychology services.

“The Better Access initiative is not providing universality or consistent equity of delivery in mental health care”

(Meadows et al., 2015, p194)

The lower rebate for psychologists of \$84.80 means that very few non-clinically endorsed psychologists can afford to fully bulk-bill clients, when taking into account office/room rental, reception costs and resources this brings the wage per hour of a psychologist down to approximately \$40/hour. After the rebate, the average out-of-pocket co-payment per session for both clinical and non-clinical psychologists is between \$31 and \$37 Interestingly, even with the co-payment at \$37, non-clinical psychologists are still charging less than the clinical psychologist Medicare rebate alone. If there was a slightly higher single-tiered payment, more psychologists could run viable bulk-billing private practices and fully bulk-bill low-income clients. Referring GPs and patients would be guaranteed no out-of-pocket costs and thereby removing any financial disincentive to seek mental health care.

Consequences of the continuation of the two-tiered system

1. **Reduced rebate for clients:** Members of the public are accessing different rebates according to the type of psychologist they see, rather than by need. All registered psychologists are competent to assess, diagnose and treat mental illness and both clinical and other psychologists see complex, comorbid and demanding presentations. Generalist psychologists all have accredited training in professional psychology, including assessment, diagnosis, formulation and treatment of mental health disorders. Members of the public are entitled to fair rebates for services, this is not the current policy.
2. **Financial consequences and sustainability:** From July 2015 to December 2016, the cost to government of psychological rebates was almost \$485 million dollars. More than half of this was spent on clinical psychologists, who represented only a fifth of the workforce (Dept. Human Services, Medicare data). With their growth increasing at 10% per year, in the next 5 years, rebates for clinical psychology services will absorb almost the entire current Better Access funding for mental health.
3. **Negative impact on psychology as a discipline:** Among the direct, destructive consequences of the two-tier Medicare rebate system is the immediate, overwhelming bias it conferred towards clinical psychology degrees. It has inflated the demand from future graduates for a clinical degree, triggering an all-but-complete bias in Australian

universities to offer clinical psychology programs. Students contemplating their financial future were naturally attracted to clinical psychology programs because of the higher Medicare rebate. Student (not client) demand for other degrees plummeted. The subsequent decline in teaching other specialist areas has profoundly impoverished mental health treatment in this country. As a result, Australia is heading towards a monoculture in the practice of psychology, which threatens its international standing within the profession. No such monoculture exists in the UK, US or European jurisdictions and Australia's bias to a single approach (medicated CBT) threatens the reputation of Australian psychology internationally.

The two-tier system has led to the unseemly public denigration of psychologists by some clinical psychologists, and consequent marginalisation of the majority of psychologists registered to practice in Australia, even though most psychologists have many years of experience and in many cases equal or even higher academic qualifications than their clinical counterparts. ***This is institutionalised discrimination and unfair work practice with no empirical justification.*** Many psychologists with advanced training in specific techniques and those who hold non-clinical post-graduate qualifications have clients who are being substantially financially disadvantaged by this process.

Employment opportunities for non-clinically endorsed psychologists across the government and non-government sector are diminishing, as agencies prefer to employ clinical psychologists to attract higher rebates for Medicare and DVA etc. Therefore, psychologists are graduating from university to find limited employment opportunities unless they hold clinical endorsement. Entry into clinical masters programs is very competitive and there is the chance that students will be deterred from studying psychology in favour of other allied health professions. This may have unintended consequences in the future if there is a shortage of qualified psychologists in the workforce to support the mental health of Australia's growing population.

5. *The Simple Solution: A single rebate*

In removing the two-tier rebate system in favour of equality and a single Medicare rebate for mental health services.

A single-tier Medicare rebate for mental health services will:

1. Significantly increase the number of Australians able to access psychological support. A higher single tier will allow more psychologists to either fully bulk-bill or lower the amount of out-of-pocket costs for patients.
2. Better control the cost and sharing of psychological care delivery long-term and prevent a financial blowout of the Better Access initiative.
3. Redress the systemic bias against those patients who receive treatment from psychologists under the lower-tiered rebate. This is vitally important to people in rural and remote areas where clinical psychologists are difficult to find.
4. Redress the partisan bias that favours one group of psychologists over others – unprecedented in Western countries and unsupported by any evidence of superior outcomes.
5. Allow patients to choose psychologists on a therapeutic needs-basis rather than choosing a psychologist based on a higher rebate.
6. Utilise and uphold the extensive depth and breadth of clinical practice expertise found within the broad scientific community of psychologists registered to practise in this country.
7. Ensure an increased availability of affordable, effective psychological assistance and reduce numbers in the public health system.

The cost of Medicare rebates is accelerating out of proportion to the delivery of public good. For example, a single-tier Medicare rebate of \$135 would provide millions of psychological services for clients without impairing the current levels of Better Access funding over the next five years. Increasing the number of sessions from 10 per year to 40 per year will enable the most complex of clients to be supported into their stabilisation phases and then into them flourishing into their lives.

The short time 10 session solution, has created clients who are forced to artificially cease treatment early and then have to wait until 1st January to recommence a process which, prolongs their suffering in quite an inhumane way. As a human being to know what I know, and to be “powerless” to do anything and then to watch a 17 year old client relapse into self-harm and ambulance trips to overflowing emergency department’s, and for her to be without family support, and suffer more significant ruptures with an ineffectually short 10 session service, and no where else to refer her to in the community. It remains vicariously traumatising to witness this, even with all the support, supervision and debriefing I personally engage in as a registered professional- Australia is a wealthy country – why are we apparently failing these people, and what must we do to change this.

6. *Conclusion*

For any successful venture we need to have a few things bedded down and in place: We need to know where we are starting from (assessment); what we are going to do (system and process) and in evaluating the effectiveness of these (evaluate), we are able to be held accountable, able to review effectiveness and plan for more success.

Currently we are failing in these processes and what I have attempted to outline here are some ideas about what would possibly have a more impactful and beneficial outcomes to our current mental health crisis and devastating suicide statistics.

Following the recent outcomes of the Royal Commissions into Institutional Child Abuse and also the Royal Commission into Banking activities, as a society, as a group, people are becoming aware of how traumatised so many of our community members actually are and exactly why this is the case. The ignorance of myth, that somehow someone with mental health issues is “weak or deficit in their psychological make-up” is readily challenged. Our courageous cultural sporting hero’s who are speaking out about their own personal stories, which always have a causal factor, which initiates their mental health crisis. Many people in positions of power in our communities have acted in the insidious state of abuser and we must redress this balance now.

For Psychologists working intimately with our communities, face- to- face and in close proximity, the results of these Royal Commissions do not come as a surprise to us, we have seen and heard so much more tragic abuses of power.

To be professionally on the receiving end of an abuse process, which seems designed, whether consciously or unconsciously, to functionally deregister 24,000 Psychologist, apparently orchestrated by our peers, and documented by the Australian Psychology Society (APS) in their August 2018 submission, has been a form of shock to our systems, which has resulted in mild mannered, thoughtful and quietly understanding professionals, fast-tracking their learning and becoming political lobbyists in a way no government has ever seen or experienced, as I am sure The Hon Greg Hunt MP can attest.

Why is this, you may wonder?

Psychologists, working in private practice know the faces of the poorest clients in our midst, (whom we choose to bulk-bill at a financial loss to our business) and the true complexity of their poverty, their trauma, the intergenerational grief and loss and their lack of opportunities, which they accept as a part of their lives. We have worked, for free (because to charge them for the report would mean that they do not eat for the week) to furnish them with Centrelink reports, which we know, takes some slight burden off them, when they arrive at an appointment with a report, which perhaps validates their suffering and supports them in communicating their challenges. This level of voluntary service, which we provide, is now not accepted as Centrelink, upon advice by “experts” who’s identities are hidden, have deemed only ‘clinically endorsed’ psychologist competent to understand the complexity of psychological injury tables which Centrelink work with. When you continue to shut people down, and shut people out, they often see suicide as the only suitable option.

All AHPRA Registered Psychologists, regardless of endorsement, have attained the competency to provide psychological treatment under Medicare and there is no evidence to date of any difference in patient outcomes for endorsed clinical psychologists compared to other registered psychologists in clinical practice. Psychologists cannot be considered better trained than each other merely by virtue of holding the title clinical psychologist or any other endorsed area. The quality, skills and knowledge of a psychologist cannot be deemed by endorsement status alone.

A working party of highly experienced private practicing psychologists, established to report to government on the variety of effective measures, which could be systematically investigated and rolled out into our communities to establish baseline measures, so we understand what our starting place is, develop meaningful strategies and apply them with suitably qualified psychologists, and have in place evaluation measures which can be applied to assess effectiveness of the treatment protocols. It’s a very simple applied socially scientific research principle.

I would like to address that the impact of applying a baseless and fictitious 2-tier divide within the profession of psychology, and what this has created, is a bitterness within the profession, which leaves many clinically endorsed psychologists, advising me of how embarrassed they feel about what has happened. Establishing parity for all Psychologists, equally, will remove this cancerous sore at the heart of mental health service provisions in Australia.

A comprehensive model of parity which can be applied across Australia has been submitted by the team of AusPsy, based on the well documented and researched, (and not cherry-picked for their own agenda), EuroPsy model. I am sure the vast majority of Psychologists would both welcome and support the logical, sound principles and grounded approach which this model presents, as an opportunity to unite our profession and move forward in our aims to serve our communities both effectively and within the best practice model.

Finally I urge The Government to consider the unwanted and unintended consequence of taking advice, which will provide a fiscally inept solution in the long term. In is in the spirit of seeking beneficial solutions that I have taken the time to think about what best serves our communities, based on both my training and professional experience, and to communicate this here; I welcome the opportunity to discuss this further.

Respectfully submitted

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Appendix A

Focussed Psychological Strategies as described by the Medicare Benefits Scheme

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)

There is also flexibility to include narrative therapy for clients of Aboriginal and Torres Strait Islander descent.'