

Productivity Commission Inquiry into Mental Health

Included are only those comments received as of 30 October 2019, for which the submitter gave their approval for use of their comment by the Commission. Some comments have been edited to remove information which the Commission considered could enable identification of the submitter or a non-public third party individual.

Comments from Mental health workers

1.	I'd like to be included in your survey about having a mental illness and working part time. I've had 18 admissions to the public mental healthcare system and have been employed for the last 8 years on a permanent part time basis
2.	I am very concerned about the way services are either cut or funded in Western Australia. For the past 2 years decisions from the Mental Health Commission and the Ministers Office, that affect frontline service delivery and people experiencing mental health issues, have been made by a few individuals including the Commissioner who has not sought any advice or feedback from the MH workforce or consumers or carers. One of the principles at the Mental Health Commission is transparency and accountability in decision making, and the WA government have breached this so many times over the past 12 months. Decisions have not been transparent or accountable and this has been exposed in documents such as the Meth Amphetamines Taskforce final report 2018 and in the Thrive report 2018 (an internal review of MHC practices including those by senior executives in the department). The WA Labor government were also elected on their platform that promised no cuts to public service or mental health and within 18 months in office have slashed frontline service delivery across the State - putting lives at risk. This has been supported by the Commissioner in WA.
3.	There needs to be a National Mental Health Act. There needs to be One National Data Base. At present each state is developing its own Data base at enormous costs . It only acts Intrastate and can't talk to the other state. At present we are still running as Colonial Models . Like different rail gauges. This inhibits the continuum of care
4.	Not enough is known in the general community about where to seek help. More information across workplaces, schools, and in advertising is needed to help people access treatment early on to prevent requiring more severe treatment later on. There are no workplace guidelines for mental health of employees or recognising the declining mental health of employees. There are a lot of youth mental health services. For people over 25, the number of treatment and support options are limited. More is needed. Many mental health services operate during business hours. This means that anybody who is working and would like to access treatment for their mental health may find it very hard to get time off or to make time to access those services. This excludes the working population from preventing a more severe episode of mental illness. For those seeking employment, not being able to access such important mental health supports due to the possibility of having

	<p>employment can be a huge barrier. Employment and study are often goals for people when they are going through their recovery, but if someone is unable to access treatment, this may dissuade them from achieving and maintaining that goal. I believe more treatment should be available outside of standard business hours.</p>
5.	<p>There is clearly an increased need for more assertive outreach in the community mental health setting.</p> <p>There is an urgency to review the current MHRB system as it currently takes up so much of Dr's time that is needed elsewhere.</p> <p>Education surrounding MH and drug issue's is much needed in the school system.</p>
6.	<p>While it is great that the inquiry is happening, we probably need a Royal Commission as is happening in VIC. I am sure that meeting all the stakeholders will raise a lot of complaints and issues. However, an overarching issue seems to be that mental health services are piecemeal and patchy in NSW. There is no collaboration between all the sectors and everyone is looking after their little patch and own agendas, while forgetting about the patient needs. I am sure private services will complain about public and vice a versa. However, I am not sure throwing more money and creating additional services is going to solve things. We need to make what exists work better. This will not happen by asking people to do more with what we have or fill in more forms (we clearly do this plenty within public MHS). One needs to review what we do first and then do it better. For eg. are we providing care to the mentally ill or are we dealing with mental health "issues". There is a big difference between the two and while we deal with those in crisis, people with serious mental illness are getting diluted services, not getting better and thus not able to contribute to society. We have early intervention services, but they are not adequately funded to provide core services such as adequate psychiatrist time, programs such as CRT etc. How would we then ensure that people recover from psychosis and go back to living fulfilling lives. Sorry about the rant but I am happy to provide more information if you like, just email me.</p>
7.	<p>If the Aust Govt is serious about improving MH; especially in regional and rural areas - there will need to be significant investment in resources. This will need to include - better resources/support for GP's. (suggest embedded MH practitioner in regions/towns with only one practice) Revamped public MH services. (currently; it is the public MH system that deals with the seriously mentally unwell. No private agency (to my knowledge) does the a/h assessments in police cells and ED departments) this is problematic and an impost on resources as public MH services have finite resources and staff burnout is rife. (consider embedding MH practitioner with ED's and larger Police stations) Devote resources and training to medical practitioners; including in undergraduate studies. The entire MH system is not seamless. There are roadblocks for people seeking assistance at every turn. This is both frustrating for consumers; families and professionals as the required care/support services either do not exist or are beyond reach. (my understanding is that MIND; in Vic; is now only taking NDIS funded clients. What happens to those not funded??) The service structure; to be effective; requires a stepped care approach; not competitive and siloed services; where people can be assessed and then easily access an appropriate service that caters for their identified needs. As they improve or deteriorate; they either step up/step down to more/less intensive service provision that meets their</p>

	<p>needs. Dementia care: with our aging population rising there needs to be exponential investment in aged care facilities. (these are the people who have built our nation and paid taxes for 50yrs) Currently; from what I have witnessed; staff are either inadequately trained or under resourced and provide minimal appropriate interventions. In rural areas; GPs clearly struggle with providing adequate services to these facilities and often as not; resort to inappropriate chemical restraint prescribing practices. Further realistic investment is required in funded home care packages; so that families can more adequately care for family members in their own environment and with adequate support; to avert aged care facilities becoming inundated.</p>
8.	<p>Mental health services in public health focus on risk management and stabilisation of clients symptoms. There are minimal opportunities to address the underlying causes because public health does not provide medium to long term psychological therapy. Additionally 10 sessions of bulk billing psychological services in the private sector are inadequate to treat these clients, so typically these people live with under treated chronic mental illness in the community.</p>
9.	<p>I'm a Community Engagement Worker for headspace and during my time here I have noticed there is a really supply and demand strain on the centers. Traditionally my role had the focus on promoting mental health awareness and headspace services. However, I come from a health promotion background and I often find my knowledge and skills in this area to be very useful. A suggestion would be to upskill people in community engagement roles to be able to do more health education work so they can relieve some of that strain and have a more preventative focus.</p>
10.	<p>The psychology services industry is currently in disarray and fracturing further. There has been a new group established to offer an alternate voice to that of the Australian Psychological Society (APS), as it has become apparent that the APS no longer represents the ideas or welfare of 70% of its members. The APS has held the ear of the Government for too long now and has voiced an opinion which is benefiting the minority of its workers ie Clinical Psychologists. The worst part is that psychology is supposedly an 'evidence-based' industry, and yet the divisions are supported by no evidence! The unfortunate result of this fracturing, and more specifically the future direction of the APS's proposed 3-tiered model of Medicare rebates, will detrimentally impact consumers. In addition to the 'bad blood' between psychologists who chose to be endorsed via different routes, there will be less psychologists in the workforce to provide services in a growing sector; there will be longer wait-lists for consumers; consumers will not be able to choose the psychologist they would like to work with, or perhaps stay with the psychologist they may have been working with. Having a tiered system of Medicare rebates for psychological services is based on NO evidence, is fracturing the industry, and will detrimentally impact consumers. A single tier will remedy all three issues.</p>
11.	<p>I work in private practice in low socio-economic areas in Melbourne. We cannot attract psychologists to our practice in these areas. Our practice previously bulk-billed under Medicare Better Access but we can no longer afford this. Many clients cannot afford a gap (especially as you pay the whole amount upfront) and PHN-referrals (formerly ATAPS) are limited in number (and they cap registered providers or have stopped smaller practices registering). The costs to run a practice are too high and remuneration (especially</p>

	<p>accounting for sick/holiday pay, super) is too low. I practice in these areas due to my values and belief that everyone should have access to medical/health care, including psychological care. Not all psychologists are willing/able to have this value. Clients in these areas are also disadvantaged by the false dichotomy that has seeped from Better Access (2-tier system) into other areas (e.g., Centrelink) . Our practice personally finds no outcome difference based on endorsement (as shown by attendance rates - retaining clients after the first session). We have had no feedback from referrers or clients indicating that they see a difference in the quality of services based on endorsement. Even so, clients seen by a "generalist" psychologist get less rebate or the psychologist gets paid less for doing the same job (bulk billing rates are lower or the gap it is lower due to the lower rebate). Clients cannot use reports from their treating psychologist (e.g., with Centrelink) even if they have been seeing them for an extended period. For example, I have 10 years experience as a fully-registered psychologist and had been seeing a client who could be identified as complex and severe for over 1 year. A report from me was dismissed by Centrelink and he had to transfer to my colleague who has less experience than me so he could gain a psychological report that would at least looked at by Centrelink. This is discriminatory to clients and psychologists (all of who are registered with AHPRA with an unrestricted license to practice - psychology is the speciality). Another issue is the number of sessions under Better Access/former ATAPS model. In the UK and USA short-term therapy is 18-24 sessions. Ten to 12 sessions is not enough. This is especially in low socio-economic areas where there is likely to be higher rates of (and more complex) psychological issues. Clients don't attend sessions when they don't need to and will finish counselling when appropriate. Under the current models clients certainly miss out on care when it is needed due to a lack of funded sessions. The funding for Better Access could be better allocated by removing the 6 session GP review and funding further sessions. Funding of sessions with psychiatrists could be reviewed? Many clients see a psychiatrist only 1-2 times per year. Funding for clients seeing a psychiatrist infrequently (or under care of GP) could be reallocated to counselling sessions as needed.</p>
12.	<p>One Medicare Rebate for all Registered Psychologists will solve a lot of issues in the profession. Consult people who work at the coalface in private practice instead of 2 prominent Psychiatrists speaking for Psychologists. Am available anytime for consultation but too busy trying to make a living to write a submission.</p>
13.	<p>Medicare has had the 2-tier model of Psychology with a higher rebate for those with the title of Clinical Psychologist with no evidence for this rebate difference. There is no evidence of a better outcome. In fact, when clients are not able to equally access experienced Psychologists in specialist areas of practice, it can block clients from receiving the expertise they need. In my view the 2-tier model or a Medicare tiered model which separates Psychologists is unhelpful for clients, the Medicare system as a whole and Psychologists. The Medicare tiered model for access to psychological sessions needs to be replaced with a Single Rebate for all Psychologists to provide Australians with equitable access to all Psychologists and prevent shortages of expertise. It appears to be competitive business interests which are in effect restricting fair trade of Psychologists with no evidence to support the trade restriction. If any tier rebate system for different types of Psychologists continues, it will serve to push out valuably needed diversity, diversely qualified and/or more highly experienced Psychologists from the entire industry</p>

	<p>because what happens in Medicare transfers to the workforce as a whole. To have a better mental health care system both now and especially into the future, people need to have equal access to all registered Psychologists, a Single Rebate for all Psychologist sessions in Medicare.</p>
14.	<p>I have the privilege of working as a family counsellor in a Not for Profit service that provides counselling to young people for free, or minimal cost (\$10) WITHOUT a mental health plan or any other plan! Young people can self refer, parents can refer and there is no limit to the number of sessions they can attend. Most of the young people who do attend have often come through other Clinical Psychologists, the higher level mental health care units (ELMHS, CYMHS) and frequently with little or no improvement of their symptoms or quality of life. Because of the way our little NFP operates, we often get young people considered in the “too hard” basket - trauma, serious mental health issues, anxiety, depression and frequently have been disengaged from school (and life) for extended periods. So what is the key difference that makes us a success in comparison to all of these other bodies? I have spent many hours thinking in this and I think there are a few key reasons: 1. Talented, committed, experienced and novel family counsellors! I am a provisional psychologist (awaiting AHPRA full rego...should be soon...but don't let this fool you). I am 47 years of age. I am a mother of 4 children, I am a wife, I have travelled far and wide. I have education (a PhD in psychology in fact) but that is not what makes me good at what I do - it's an incredible depth of life experience with humans of all walks, shapes and sizes! I also work alongside other psychologists who have all done extra training in family therapy, studied widely and we all continue to study and learn every day. We are solution focussed, not illness focussed and we work with the whole system - whatever that system looks like (families, schools, kinship carers etc). It works because we are good at what we do. 2. No limit of sessions/ period of care - We take them in, we work with them, we hold them for as long as they need to get them where they need to be. For some young people this is 8 sessions, for some its 50. But we don't give up. We also don't take a case and then refer on after 6 sessions (like so many other services). This is highly stressful and has hugely damaging effects on young people, especially if they have suffered trauma and trust is an issue (almost all). Taking the time to share and really open up with someone takes time....not limits on sessions I think the current push towards a medicalisation of mental health (as opposed to a health focussed model) and the push for all complex cases to be seen by Clinical Psychologists is a serious mistake (waiting lists already in overload, focus on diagnosis, not wellness and protective factors, lack of research supporting better outcomes with clinical focus...the list goes on). I urge you to look at how you can better help our youth - More sessions, more choice of therapies and therapists, more involvement of families, and PLEASE do not make them change counsellor when they don't fit the model/number of sessions etc. continuity of care!</p>
15.	<p>I work as a self-employed Counsellor and Psychotherapist and I strongly believe if Medicare were covered for counselling clients as well, there will be less suicide in Australia next to more young people having to suffer less as they would be able to receive counselling and psychotherapy in a more holistic manner. A focus on male mental health is needed in Australia as well. The male clients I have had prefer me as a Counsellor over a Psychologist or Social Worker due my holistic approach in my work.</p>

16.	<p>EARLY prevention through perinatal and infant mental health services are essential to support new families to parent with support and care, addressing their own childhood issues and to develop strong and healthy attachments with their children. I work in child and adolescent mental health and I have worked in adult mental health. Most common adult diagnoses begin in childhood, have a bio-psycho-social basis and will not manifest into difficult to treat mental health diagnoses if treated in the family system in childhood. TRAUMA INFORMED CARE in the education system is critical. I work alongside schools in rural settings and they are grimly under-resourced to understand and to cope with students living with the impact of trauma in the school settings. The impacts of family violence in school include disruptive classroom behaviours, poor learning outcomes for students and traumatised staff members. Staff are not trained to understand the signs and symptoms of trauma in their students and often reinforce the trauma through their discipline. I think trauma should be taught in undergraduate courses and then re-inforced in applied professional development. Please just pay psychologists the same amount of money for providing the same service. Registered Psychologists, Area of Practice Endorsement Psychologists are all the same - their therapeutic skills are not learnt at uni, they are learned in the workplace and with sound supervision. Let consumers make the choice of who is good and who is not good and who they seek for treatment. A degree does not make a good teacher or nurse or doctor, or psychologist. The way they approach their work, their rapport with clients, their workplace is the same. Leave the decision of who is more qualified to provide service to clients and save the government money by providing a flat fee for therapy services to all providers across the board. Neuropsychology services could attract a higher fee, however I cannot see the differential benefit in psychology services between community based therapy providing psychologists and until there is evidence to indicate such. The APS green paper indicates using a stepped care model with only Clinical Psychologists treating severe cases - what is severe? How is it determined? Then must a "severe case" be moved from the psychologist with whom they have developed rapport, trust and safety to start again with a new psychologist? Trauma informed care would say an emphatic "NO!"</p>
17.	<p>I suggest the Federal Government subsidise data charges were made to Peer Forums such as those listed below which are of proven worth: There are recognized Mental Health Peer Support Forums such as Beyond Blue's Support Forum and SANE's Lived Experience and Carers' Forums which assist those with Mental Health Conditions of all natures by providing contact with others who have similar experiences, and also some professionals. These forums are accessible by internet data only. At present in remote areas, and more generally on limited data plans, such access incurs a charge by the consumer's ISP/NBN. This can make access either very limited or totally impossible and denies the consumer use of these beneficial facilities..</p>
18.	<p>This commission is sorely needed and an enquiry into why only certain members of the helping professions are deemed fit to provided crucial supportive psychological services</p>

19.	I think one of the most important parts of improving mental health to benefit society is to remove the stigma and marginalisation that many users of mental health services face. Mental health workers and services play a vital role in providing appropriate care, but it is important for employers and services within the community to be accepting of people with mental health issues and to facilitate them in working and contributing to the community.
20.	Psychtherapy should be government rebateable service if provided by members of such organisations as PACFA. A mental health plan isnt necessary for a psychotherapist to assess a clients needs- their training provides this . Thus gps money is saved . The psychotherapy industry has changed vastly over the years and if used correctly as a government rebateable service , in the long term ,money spent on mental health by the government will be well spent , and saved in terms of the relevant treatment being given by clinicians who have a very different and far more effective treatment than psychologists
21.	We are the headspace Hawthorn Youth Advisory Group. We are writing this comment as young people who come from a broad range of personal experiences. During our time through the schooling system, a number of things came up that need attention in the future in regards to mental health in students. In particular, more training for all staff and teachers around mental health, suicide and in particular panic attacks. Many of us recall experiences of such incidences occurring with the only support person available being a wellbeing staff. However, often this staff member is either really busy, not suitable to our needs or unapproachable. Instead there was often a teacher we liked and trusted however couldn't go to them as they weren't the allocated well being person. This is at every level of schooling, even with the administration - a student missing school might mean they're not coping rather than assuming their just lazy. This kind of awareness needs to be understood in schools. We also believe there is a need for more awareness about the eligibility of some people to access 10 free sessions of Medicare. A lot of us agreed that we never reached out for help because we presumed it would be difficult and expensive. Thank you for reading our comments.
22.	[COUNSELLOR] Although a late post, I believe there are some valid comments to make about access to mental health professionals for a particular social group i.e. older people living in any home setting including residential care. The Inquiry appears to consider mental health in relation to economic participation, productivity and economic growth. However, older people, long retired and economically unproductive (except they may volunteer), may experience poor mental health for various reasons such as grief and loss, or depression as a result of moving home where they have strong connections to one where they may have lower levels of connection, or a move from a stand-alone family home to community living in a retirement village with rules for a new way of living. I am not a psychologist or mental health social worker but a counsellor who uses counselling skills to support older people at home. Over the past few months, I have supported an 82 yo woman who has gambling addictions as well as through the crisis of loss of connection with her son. A 62 yo woman is caring for her 65+ husband as well as a 26 yo son who has gambling and drug addictions. A 66 yo woman with MS has problems with social skills and feels victimised. Why did



<p>they not see their GP for a mental health plan? Among other reasons, were the cost of psychological services and the anonymity of support. I recognised the need for counselling some years ago, due to a long and varied experience in aged care. I completed a postgrad program (pending student debt) but have had little opportunity to use my degree where I see value. Counsellors are not respected nor validated by the health and aged care system. We are locked out of work options and cannot get clients as we don't have access to Medicare rebates. More recently, a PHN commissioned mental health services to residential facilities through a group of psychologists. Here was reason to use a range of mental health professionals in a space where older people do not necessarily need to see a psychologist. A stepped approach to mental health must also include a range of professionals. Counsellors can support people with mild mental health issues and be part of the early intervention phase. Ignoring counsellors in aged care means that older people have less options. Counsellors should be allowed to support older people in any aged care space (RACFs, HCP, CHSP) and non-care space so that people can remain engaged and assisted to deal with their issues. Evidence suggest that older people are at higher risk of suicide. All the more reason for counsellors to be involved!</p>
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Comments from Providers of mental health services or supports

1.	<p>Through all the work that the NT government is doing around Trauma informed practice and restorative justice, I have seen some positive change in our young people but to start to highlight the positive through work such as healing centred engagement is essential in moving forward. The Balanced Choice program utilises fitness, theatre and hope theory to make a positive change in young people lives in the Territory, in the program we talk about being fit inside and out. Since working with the young people I have noticed that so many of the issues raised by are based around impulse control and drug use. The more work we do with our kids about opening up and sharing, allowing them to have a safe place with influential adults who are consistent in their lives is paramount. We need more groups and more open discussions on issues for young people. I also believe that as a society we need clear programs that allow adults to be adults and kids to be kids and we need to be able to learn from each other. As a society we need to build the art of connection because isolation is our biggest killer.</p>
2.	<p>I comment as both a health professional & a family member/carer of a young adult with chronic complex mental health (MH) issues. The stark contrast between funding & services for comprehensive cancer care and moderate to severe mental health is worth the commission examining to give perspective on how poorly resourced MH has been for decades. The inequitable distribution &, in many outer urban, regional & rural areas the complete absence of affordable, more intensive & longitudinal evidence based psychotherapies (eg DBT, schema therapy, CBT-E, CBT-T, CAT); the inconsistent, stigmatising, generally unsympathetic & often unhelpful &/or traumatic crisis care in Emergency Departments; the inadequacy of staffing levels &, in some cases, their low level competencies, as well high staff turnover & lack of funding for tertiary MH services; the absence of longitudinal outreach support by suitably qualified & well supported MH professionals; the complete absence of continuity of care in public psychiatry; for people who require more intensive & longterm psychotherapy, and cant afford gap fees, the inevitable need to either stretch 10 medicare funded sessions of FPS over 12months, or go without in the latter part of each calendar year; the paucity of psychiatrists who live & work in regional and rural areas; the cumulative cost of gap fees in private psychiatry, particularly sub-specialist psychiatrists, & of experienced clinical psychologists; the high turnover/burnout in many groups of mental health professionals; the lack of medicare funding for holistic & thorough GP services for MH (eg for long consults, consultations with parents/carers & others, phone liaison); lack of emergency & public housing, difficulty of getting timely financial assistance, & lack of in-home family support all add up to have a predictably negative & long-lasting & wide-ranging economic impact. This constellation of factors (& many others) inevitably results in less likelihood of recovery, less access to effective relapse prevention and treatment, poor school engagement, unsatisfactory school progress, un- or under-employment, inability to achieve independent financial security & increase the risk of substance abuse/dependency, contact with the juvenile justice system, long term social disability & reliance on Centrelink. Add to this list, the financial & other tolls on families & carers (eg time off work, carer leave, loss of employment, doing crisis care including "suicide watch", other costs, & on-costs of carer</p>

	<p>stress). Finally, the very limited availability and high cost, if done privately, of cognitive, learning assessments and neuropsychological assessments results in inadequate assessments and treatment of young people struggling with learning, behavioural difficulties, the social & emotional impacts of neurodiversity (eg ASD,ADD) and childhood & adolescent trauma related difficulties, all of which predispose to complex & long lasting MH issues.</p>
3.	<p>We currently run a program (MHCRP) in regional NSW to support people with a MH diagnosis and their carers with practical support for ADL's. This program will be terminated in June, as it is assumed that all of the clients will be transferred over to NDIS by then. Many of our clients have been deemed ineligible for the NDIS, but without support of this program it will inevitably result in multiple readmissions to Mental Health Units, and increased stress on already strained relationships with family and other informal supports. It is very concerning for those that do not qualify for NDIS as they are going to fall through the gaps. Further to this, many have had their applications to NDIS turned down multiple times as there does not appear to be any consistency with approvals. This has also resulted in already vulnerable people feeling unworthy and suicidal when their applications are turned down. These people need support and I am afraid they will be left in limbo.</p>
4.	<p>I have completed three research studies on the impact that laughter has on mental health and we have found the following in our results.</p> <ol style="list-style-type: none"> 1. Laughter has an instant impact on people's stress depression and anxiety levels. 2. The more regularly they laugh the more is the impact on decreasing these levels. This meant that you can never get too much laughter in your life. 3. When the programs finished the attendees experienced lower levels of anxiety and depression that meant that they had been changed permanently over time. <p>We have also conducted Practice Based Evidence surveys that show that people who laugh regularly can reduce, and in some cases, eliminate their medications. The points that I'm sharing here is that there are cheap effective alternatives to dealing with the growing problem of the side effects of mental health medication. Through laughter, people are less likely to get stressed depressed and anxious in the first place. And finally, people who laugh are happier and happiness which is all about emotional and not mental health. Our conventional health system, and current way of thinking, is there is only mental and physical health. We need to broaden our thinking into emotional health also. What if the problem is that we are aiming at the wrong target, and so hitting it is actually missing. Food for thought.</p>
5.	<p>I am concerned about the cost of primary health networks. As a front line worker (clinical psychologist) I have long been concerned about how much money goes into administration and PHN's appears to epitomise this extravagance. The logic appears to be that local networks are better informed about local needs and therefore can provide better services. In these days of online communication geographical boundaries are decreasingly important, the mental health needs in one area are not that dissimilar to those of another area, and administrators, wherever their locations are not necessarily connected with local needs, all of which mitigates against the need for all these micro administrations and their associated cost.</p>

6.	<p>I oppose the 3-tier system for the following reasons. There is no evidence that clinical psychologists provide a better service than registered psychologists. Many registered psychologists have years of experience working with clients with severe mental illness. The Green paper states that GP's will have to make the initial assessment of severity of the client's condition which many involve additional training and subsequent high costs. If Clinical Psychologists are the only practitioners what can see clients with severe mental health issues, there will be long waiting lists and some clients will miss out on services altogether.</p>
7.	<p>As a psychologist who has worked in private industry (employment services), community organisations and now in private practice, I see that there needs to be a diversity of ways in which people can access mental health supports. Keep it simple with Medicare, one tier, one rebate. We need a diverse workforce of psychologists who could be enticed to bulkbill or have a small gap if they could make a liveable wage. Clients need to know that when they start with a psychologist, they will be able to continue with that psychologist.</p>
8.	<p>Getting to the bottom line.... there are real people in the community who require the services of qualified, experienced Psychologists. they are not interested in statistics/ budgets / priorities other than their own. I am a qualified Psychologist - undergrad and masters from UQ and have 25 years experience. I have worked in Australia and overseas, gained registration with HCPC IN UK. the most important aspect of successful intervention is the ability to connect with the client, establish a therapeutic alliance, gain their commitment to therapy and willingness to change. I have documented evidence of many many many successful outcomes for clients. Being an endorsed clinical psychologist would not have improved my performance / intervention / success in any way. Would the AMA dare to suggest one area of speciality is superior to another? would the person be deemed to be better educated, more intelligent, more capable.... superior ? It is a fact that when psychologists graduated 20 + years ago there were no areas of endorsement, no requirement for college membership and no demarcation barriers. If the ideology has shifted, then let it apply to NEW graduates who do not have the benefit of years of experience.</p>
9.	<p>The Better Access Initiative has helped numerous Australians recover from or cope with significant mental health challenges. The present system though can be improved by streamlining the system for Psychologist by creating 1 tier instead of the present discriminatory and fiscally inefficient 2 tier system. The present system requires the Australian public to pay more for seeing the psychologist of their choice if that psychologist is not a clinical psychologist. Clinical Psychologists are rebated at almost \$40.00 more per visit, despite research by the Govt showing no difference in the outcomes between Psychologist and Clinical Psychologists. Recent data shows that Psychologists saw more Australians than Clinical Psychologists in the last 12 months whilst costing the Australian Tax Payer less money. This system does nothing more than line the pockets of Clinical Psychologists. The Australian public deserves 1 tier and for all psychologists to paid the same rebate. Additionally, the present system that offers Australians 10 sessions per calendar year is insufficient for all but the most straightforward fo mental health problems. Typically, most clients run out of sessions by mid year and then have to rely on their own resources to fund the appointment entirely or wait until the following year. Some</p>

	<p>psychologist will sacrifice their own business standards and see clients for free or little funding out of duty of care. This is an unreasonable position to put any hard working Australian in. With regards to workplace mental health. Despite the best efforts thus far to encourage the recognition of mental health in the workplace worthy of support, employers, including Government employers still use mental health issues as a mechanism to trigger discrimination and isolation. The common worker does not feel "safe" disclosing what is seen by many as a weakness. Workplaces would benefit from having all staff (including the highest level of the State Executive Services) under go trauma informed practices given at least 25% of the population (and up to 80% of the population with a disability) have been the victim of either verbal, physical or sexual abuse.</p>
10.	<p>In Bunbury, Western Australia, there is a huge demand for inpatient mental health services and not enough beds or resources for the region. Particularly, we have the population for Mother-Baby Units for families impacted by Post Natal Depression (particularly psychosis) and having these units in the South West Region would be utilised and provide a huge benefit for the population.</p>
11.	<p>Please lift the restrictive differentiation between psychologists under Medicare MBS. Outcome measures show no statistically significant differences between endorsed (including clinical) & other registered psychologists.</p>
12.	<p>The current system medicalises mental health. People who are suffering are given medication as a first action because of huge waiting lists for medicare funded places when it should be last resort. There are alternatives and people should be allowed choice. The current system is not working as shown by latest suicide statistics. Therapeutic groups as well as alternative therapies like meditation and resource therapy need to be supported and promoted so people know there is hope and there is choice available.</p>
13.	<p>Dear Sir / Madam, I write to you extremely disappointed at the lack of empathy within the whole of the mental health field for other clinicians and the clientele who use Mental Health services. The Medicare rebate has become a competitive marketplace whereby the clients and practitioners who do not have rebates have been forgotten about. It's become traumatic for clinicians who do not receive rebates. Practitioners with Medicare rebates are regularly increasing their rates, practising in ways they should not (e.g. providing relationship therapy when it's unethical and fraudulent - i.e. the rebate is not designed for that). There are a many psychologists and social workers who are doing what they should not be doing. This goes against the government's own ACCC – and is anti-competitive practice, whereby they have an unfair advantage where they should not. Many psychologists are not even trained in relationship therapy and I am. More SERIOUS and proper auditing needs to be completed within the program to prevent further fraudulent behaviour. As a trained counsellor, coach and psychotherapist - I can provide a multitude of services, though it's been really difficult running my private practice against the psychologists regionally as they have the numbers and the rebate. It's a testament to the quality of my services that I have been able to continue and have survived the onslaught of psychologists in the field and the continuous churning out of psychologists from our local, regional university. Psychologists are trained in psychology. I am trained in professional counselling and psychotherapy. Psychologists make out that they have as</p>

	<p>through a training as mine when it comes to people skills. The courses in psychology don't cover enough the people skills that are required when working with the general public and mental illness. Of course, they train thoroughly, though it is focused on statistics and not enough on aiding the people that need it most – and being human with such people. It is absurd, when I hold a Masters and I'm a member of a professional association, that psychology practitioners can get rebates and I don't. In addition to the above issues, there are a multitude of practitioners joining the online therapy / telehealth field that should not be. In-depth training is required for tele-mental health services in order to properly service clients. The current scheme of Telehealth training is not sufficient. Nobody talks enough about safety, security and encryption! I have recently completed a 5-month long course with an international provider of online therapy training services - and I provide in-depth online therapy training for mental health clinicians in Australia. It is essential that Australians have the best qualified people in the world - given the state of the world currently. It is remiss of the government not to encourage better and proper telehealth training. I am happy for you to be in touch with me.</p>
14.	<p>The Adverse Childhood Experiences Study (ACES) show the direct relationship between exposure to violence and trauma in childhood and the development of mental and physical illness. The recognition of PTSD in children was not formalised until DSM5 in 2013. The ACES questionnaire should be used to identify children and adults who have experienced high levels of toxic stress. They should be assessed for complex PTSD and referred to therapy for treating trauma as recommended by WHO (TF CBT and EMDR). They should not be referred to low level trauma informed care which will only exacerbate their symptoms and extend their distress. PTSD can be cured if treated correctly. Complex PTSD leads to the most extreme psychiatric and personality disorders which make up the highest level of demand on the system. All mental health workers need to be trained in recognising PTSD and how to treat it, reducing the chance of homelessness, substance abuse, suicide, depression and early death.</p>
15.	<p>APS Green paper for MBS is not fair for all psychologists. Many registered psychologists are against it. The model does not promote community of care. The level of severity should only affect number of sessions given not WHO provides the sessions. I support 1 tier system for all psychologists. Never support 3 tiers.</p>
16.	<p>I am a psychologist working in private practice. I have over 25 years of experience. I wish to endorse a single Medicare rebate for clients attending counselling therapy with a psychologist. All psychologists should continue to be allowed to work within their area of competence, without any of the undue restrictions of trade and limitations proposed in the Green Paper by the Australian Psychological Society (APS). The APS is not representing a fair or reasonable model for the Australian public in need of mental health services, psychologists in private practice or even their paying members. The federal government must support an ACCC case against the Australian Psychological Society (APS) and the Psychology Board of Australia (PBA) for anti-competitive activities in their promotion of clinical psychologists, endorsement processes for psychologists, and the barriers for registered psychologists to continue to provide mental health services. The federal government conduct an investigation into the undue influence of pharmaceutical companies and their lobbyists (prominent psychiatrists) on mental health policies and</p>

	<p>funding. For example, the “double dipping” whereby Headspace receive funding from the government, yet psychologists are employed as contractors and paid bulk billed rates via Medicare. This is in stark contrast to the current arrangements in place in Residential Aged Care Facilities where residents cannot claim Medicare rebates if they receive support, counselling or therapy from psychologists as the facility already receives government funding. The federal government accept the recommendations of the Medicare Review Mental Health Reference Group to expand the Better Access program so that clients can choose who they see, obtain more assistance from all psychologists equally, and without being financially penalised for their choices. The federal government remove the inequities in Medicare rebates and the unrealistic restrictions on the specific types of services psychologists may provide (i.e. Focussed Psychological Strategies Vs Therapy). I endorse the following submissions: 460 by AusPsy 462 by Sharon Hulin 388 by Jenny Corran 47 by Blue Knot Foundation 90 by Karen Donnelly 357 by Name Withheld</p>
17.	<p>I provide psychological therapy for volunteer parents whose child has been removed by the Child Protection Department DCP in South Australia. South Australia has had 3 Royal Commissions into the DCP system during my career, by Layton, Mullighan and Nyland. In the last 2 months clients have made the following comments to me.</p> <p>Client 1 is a grandmother of Aboriginal descent who has fostered many children. Her foster children were removed after what she describes as an inaccurate allegation. When she spoke of appealing to Court her social worker made 2 comments in the presence of seniors: 'We don't need approval of a court,' and 'We are above the law.'</p> <p>Client 2 is a mother aged about 23 of Aboriginal descent with 2 young children. Her children were removed from her care and she was made homeless by an order prohibiting her from being in the house while her children were there. A Court order lapsed. DCP told her partner they would remove the children from his care using a safety plan if he did not comply with heir demands.</p> <p>Client 3 is a 17 year old woman who had her baby removed from her care at birth. The primary justification is that the client's own mother was an inadequate parent as both parents were drug users. I have completed an attachment assessment and assessment of parenting capacity and consider there was no need to have removed the baby from the client's care.</p> <p>It is apparent DCP has no structured way to assess either attachment or parenting capacity, and uses opinions of staff where assessment procedures vary widely and do not reflect current scientific information. In my opinion, Royal Commissions have proven ineffective in changing a dysfunctional system, and changes in legislation are required to bring consistency between the Family Law Act and Child Protection Acts.</p>
18.	<p>Qualified, registered, professional Counsellors and Psychotherapists are excluded from the Medicare system. Their services, which are most often the first line of defence in primary mental health care, are consequently under or un-utilised by referring general practitioners and by the public due to the out-of-pocket costs that the patient must bear.</p>

<p>The Better Access Initiative provides subsidised access to limited psychological services that are of triage character at best, and inadequate for first world patient care, and result in repetitive annual triage for the same patient for the same mental health issue - with the same inherent flaws. The result is a cycle of inefficiency - and patients who remain in distress forever.</p>

<p>It is imperative that qualified, registered Counsellors and Psychotherapists be accommodated within the Medicare system, with the aim of providing subsidised primary mental health care that is affordable for consumers. This will encourage more ill Australians to access the help they need - help that a large percentage of needy people will not currently seek, simply because they cannot afford it.</p>
