Submission to the Productivity Commission re Mental Health- Jenny Corran, Psychologist

Research has revealed that the mental health indicators over the last 2-3 decades have failed to improve, despite billions of dollars being spent primarily on psychiatric services. Clearly, something is wrong.

Executive summary

There is currently a lack of fairness to Australians suffering psychologically based mental illness as a consequence of the two-tiered Medicare psychology rebate system. The arbitrary, unfair and highly discriminatory distinction in the Medicare rebate system, Better Access Scheme, between clinical psychologists and all other psychologists. This distinction between equally trained psychologists is unrelated to their skill, level of qualification, or professional competence and, regrettably, Australia is the only country to make it.

Clinical psychologists are not the only psychologists equipped to deal with serious mental illness and there is no empirical evidence or theoretical basis to support the view that Clinical psychologists may be "best equipped" to do so.

All psychologists are registered under the Australian Health Practitioners Regulation Agency (AHPRA) and are extensively trained in evidence-based psychological therapies to treat both high prevalence and serious mental health disorders. They are skilled at assessment, diagnosis and treatment of the community mental health presentations that the Medicare rebate system, Better Access scheme, is intended for. The two-tier system in Medicare Better Access Program or the Stepped Care Program would limit access to experienced practitioners who are unable to practise in areas where they have specific expertise.

1. Mental Health Workforce.

In Australia psychologists are registered with the Psychology Board of Australia (PBA) to provide mental health services and psychologist provided the majority of mental health services to the Australian public. Over the last 23 years, the Australian Psychological Society (APS) leadership has been led by only clinical psychologists. These mostly academic clinical psychologists have had leadership positions in the APS, as well as the PBA. There appears to have been a concerted political effort to enhance the position of clinical psychologists over all other psychologist. This has occurred by the leadership of the APS and PBA who advocating a false narrative which disparaged the competencies of all other psychologists. Based on no evidence the board of the Australian Psychological Society (APS), the peak professional body, presented a formal submission to the then Health, Minister Tony Abbott in 2006, recommending that only clinical psychologists receive Medicare rebate.

The APS executive had been dominated by members of the College of Clinical Psychology since 2001. When the Howard government introduced the Better Access to Psychologists and Psychiatrists program, the APS wanted to include only clinical psychologists in the program. The then Minister for Health

recognised that clinical psychologist could not service all the mental health needs of the general public, and therefore included all registered psychologists in the Better Access program as mental health service providers.

Melbourne University researchers (Pirkis et al 2011) evaluated the Better Access program, and provided evidence that:- registered and clinical psychologists both provide services to people in moderate to high need categories; both registered and clinical psychologists undertake the same work with clients, providing the same services; both registered and clinical psychologists achieve outcomes with clients which are comparable with the best international standards of psychological care. That is, there were no demonstrable differences between the clients, the quality and the nature of the services provided, or the outcomes between different types of psychologists- all did the same work, with the same clientele, achieving the same impressive results. Despite this evidence, and in the absence of any evidence showing differences, the Medicare subsidies for services provided by clinical psychologists are nearly 50% more than the Medicare subsidies paid for services provided by registered psychologists. There is simply no evidence that can support such a differential in subsidies.

Note: the main difference claimed between those now deemed clinical psychologists and those now deemed registered psychologists is that clinical psychologists are said to undergo a masters degree in clinical psychology as their 5th and 6th years of training; whereas registered psychologists undergo a two year on the job internship as their 5th and 6th year of training. Both training pathways have their advantages and disadvantages- there is no research evidence to indicate that either results in superior practitioners. In fact, the only available evidence (Pirkis et al 2011) points towards there being no differences. However, contrary to the rhetoric, around 42% of those now deemed clinical psychologists have no masters or doctorate degree in clinical psychology at all, but were simply “grandfathered‟ into the status by virtue of belonging to the APS College of Clinical Psychologists- a choice that was open to all psychologists in the past. And many registered psychologists do have masters degrees and PhDs in psychology.

The psychology profession in Australia has been wracked by division and conflict as a result of this arbitrary defiance of the research evidence. Thousands of psychologists have been disenfranchised and struggling to provided the severs to their clients because their own Society has not acted in their best interests. Inexperienced clinical psychology graduates, fresh out of University, have been able to offer almost 50% higher rebates than psychologists with ten or more years experience in the field.

Naturally for the past twelve years students have followed the money and almost exclusively signed up for clinical psychology courses. This division in rebates are not happening anywhere else in the world. Clinical psychologists within the APS and PBA continue to push the advantage of clinical psychologists. Which has resulted in the exodus of highly competent, experienced and skilful psychology practitioners leaving the mental health sector. The Australian public has suffer as a result, via fewer skilled and experienced practitioners being available to meet their needs. Who have been replaced by fewer, young

inexperienced clinical psychology graduates who are simply not equipped to meet the public's needs. The public has suffered in terms of more poorly treated mental health problems, more extreme levels of disability and more suicides as registered psychologists have been forced out of the mental health workforce. The APS and PBA are complicit in this state of affairs.

In addition, the Better Access program was reduced in scope when client's allowance for psychology sessions were reduced from 18 to 10. International research demonstrates that it takes around 20 sessions of psychological therapy to adequately address most mental health problems, such as experiences referred to as depression and anxiety (the most common presentations). Prior to this reduction, Pirkis et al (2011) had demonstrated the high level of effectiveness of the Better Access program in terms of client outcomes. Any research now purporting to demonstrate a lack of efficacy of the program is simply reflecting the deleterious impact of reducing the sessions from 18 to 10. Removing interventions that work, such as the Better Access program, in order to replace them with more psychiatry and psychiatric drugs will simply compound the problems.

There are several prominent biological psychiatrists who have acted as outspoken critics of the Better Access program- Patrick McGorry, Ian Hickie and John Mendoza. These have been the most influential in providing advice to successive Ministers for Health in regard to mental health policy over the last 20 years. They are now disparaging Better Access psychologists to take the focus away from the Productivity Commission's findings that despite many billions of dollars being spent (primarily on psychiatric services and products, like paying psychiatrists $380 per 45 minute consultations, and subsidising psych drugs), the mental health indicators have got worse over the last 25 years, not improved. Their advice and policy direction has demonstrably failed miserably- but rather than take responsibility they are blaming Better Access psychologists (whose services have only ever been a minor part of the mental health spend). Their attacks on Better Access psychologists are nothing more than a strategic diversion away from the facts of the matter. Biological psychiatry, which they are vigorously advocating, has failed to help the Australian public- in fact, the Productivity Commission figures suggest it has harmed the public.

Hickie is arguing in many media outlets that the Better Access program has failed to increase accessibility for the public. He is suggesting, rather, that the funds should be diverted into Public Health Networks (PHN's) and private mental health 'hubs', such as his Headspace centres. However, there is simply no evidence to suggest that this would increase accessibility for regional or rural people. It will still be a matter of service providers having to be near those in rural and remote areas. Given that private practicing psychologists tend to work in the communities in which they live, which is spread across the population (Note: it is only clinical psychologists and psychiatrists who tend to provide services only in the wealthier urban areas; this is not the case for registered psychologists or social workers providing services under the Better Access program- Pirkis et al (2011) are more likely to make psychological services accessible in community locations than PHN's or 'hubs'.

Hickie is also arguing that there is a quality problem with the Better Access program, ie. registered psychologists are failing to provide high quality care for those with moderate to severe problems. The only relevant research, conducted by Pirkis et al (2011) demonstrated very clearly that registered and clinical psychologists in the Better Access program provide services for people with moderate to severe problems; and obtain outcomes which are comparable with the best international standards. Any data which contradicts this is simply the result of having reduced the amount of sessions from 18 down to 10 per year. International research shows very clearly that most psychological problems require around 20 sessions for a positive impact. The Medicare Review Mental Health Reference Group (MHRG) has recommended bringing the Better Access program in line with the international research which supports more sessions for those in more need. Most consumers in the Better Access program do not require an extensive amount of sessions, but those in most need do. The MHRG recommended extending the amount of sessions for those in need. If this is acted upon by the government, it is likely that any negative research findings will turn around and again reflect the benefits of those in most need having more sessions (as was the case when Pirkis et al (2011) did their research (when consumers were able to access 18 sessions per calendar year).

Psychology has been demonstrated to 'work'- 80% of people with a particular problem who are receiving psychological help are doing better than those with the same problems but not receiving help (Duncan & Miller 2000). Pharmaceutical psychiatry has not been demonstrated to 'work' (Moncrieff 2009; Rose 2019). The inefficient spend in mental health is not on the relatively small amount of funds that go towards psychological services, but on the much larger part of the pie that goes on biological psychiatry (private psychiatrists being paid $380 per 45 minute consultation, in-patient biological psychiatric treatment, and psychiatric drug subsidies).

The APS has been literally inventing the false narrative for over two decades (suggesting that registered psychologists are not adequately trained to provide clinical services). Prominent psychiatrists like Hickie, McGorry, Mendoza etc are simply using this APS-made fabrication in order to remove psychologists from the sector, and to have the funds diverted to their psychiatric programs and services.

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

1. AHPRA recognises that all psychologists are registered and able to carry out psychological services without any restrictions. Thus, according to AHPRA all registered psychologists are fully qualified and competent. AHPRA's endorsements are recognition oriented not related to MBS categories, item numbers or fees. In fact, general registration in psychology is a licence to practice the full scope of psychology, thus it confers the title 'clinical' on all registered practitioners. Thus, all should be upgraded to the higher rebate.

All psychology pathways to registration and practice are subjected to rigorous development and stringent monitoring to ensure the same baseline competencies are upheld. 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. This is highlighted by the scientific evidence;

2. Expert clinical practice provided by all psychologist involves a complex mix of practice experience, supervision and professional development as key variables in treatment outcomes – beyond academic qualifications. A notable research project commissioned by the Australian Government (Pirkis et al, 2011) 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; 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. All psychologists are required to complete Continuous Professional Development that is relevant to the scope of their practice and interests.

Recommendations:

a) A single Medicare rebate for all psychologists providing the same services. In any new model of psychological care such as the proposed Stepped Care its vital to have a single tier payment for all psychologist and that all psychologist can provide equally services in all levels of care.

b) The federal government support an ACCC case against the APS and PBA for anticompetitive activities in their promotion of clinical psychologists and barriers to registered psychologists in their provision of mental health services.

c) The federal government conduct an investigation into the undue influence of pharmaceutical companies and their lobbyists (prominent psychiatrists) on mental health policies and funding.

d) The federal government accept the recommendations of the Medicare Review Mental Health Reference Group to expand the Better Access program so that those in most need will be able to obtain more assistance from registered psychologists, social workers and clinical psychologists equally.

e) The federal government remove the inequities in subsidies between clinical psychologists and registered psychologists - so that service consumers are able to access the practitioner of their choice without being financially penalised.

2. Prevention and Early Intervention:

Early intervention needs to operate in a non-stigmatising manner, ensuring that the cost to the consumer of involvement with a mental health professional does not entail damage to their self-

concept. The Medicare Review MHRG has advocated that Medicare subsidised services be made available for early intervention with people who are not yet suffering from established problems in living but are vulnerable to doing so. Personal counselling and support is able to meet this need, and can ensure that problems are addressed early in the experience rather than waiting until they become chronic and intractable. Expenditure made at the early intervention stage will prevent much higher levels of expenditure at later times.

Given what is known about the social causes of psychological problems, it makes sense to target prevention efforts at those social determinants. All forms of social disadvantage are relevant here. These include:- poverty; restricted options and opportunities in life due to lower socioeconomic status; culturally/socially inappropriate educational experiences which alienate certain groups in society; racism; sexism; stress which results from all these forms of disadvantage, which result in poor life choices regarding substance abuse, and poor parenting behaviours. Such problems manifest in trauma responses in those suffering them, and subsequently manifest in experiences and behaviours which are then viewed as evidence of mental health problems. Essentially, social-cultural-political-economic problems manifest as individual mental health problems (or more accurately, our individualist Western culture makes sense of these manifestations in terms of individual problems in living). As such, genuine prevention lies in the area of addressing social-political-economic disadvantage with social change efforts. This requires a macro-level analysis and suite of interventions. In a humane society, such a focus also needs to be joined by a micro-level of support, as people are suffering now and cannot go unsupported while waiting for macro-level change to occur. The political will for such macro level change is often absent amongst policy decision makers.

Micro-level support entails providing psycho-social assistance those who are suffering from the individual manifestations of macro-level problems in a non-stigmatising, non-blaming, nondamaging manner. This goal is simply inconsistent with the medical model and biological psychiatry, with its emphasis on stigmatising labelling and drug & ECT intervention. Psychosocial help and support come in many forms, from peer support, community development aimed at overcoming social isolation, self-help and mutual support movements, through to supportive counselling and intensive psychotherapy. A range of psycho-social practitioners can provide these roles, along with people with lived experience.

Recommendations:

a) The federal government boost funding to the Better Access program, enacting the recommendations of the MHRG pertaining to early intervention with people who are not yet suffering from a „disorder".

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