Australian Productivity Commission
Inquiry into Mental Health

8 April 2019
(Extension provided by Rosalyn Bell Assistant Commissioner via email 8th April 2019)

Dear Commissioners,

Thank you for this opportunity to provide feedback, I am grateful to be able to contribute.

I am a registered Psychologist, Medicare provider and registered with the Australian Health Practitioner Regulation Agency. I am also a member of the Australian Psychologist Association, although given they have not been adequately representing Registered Psychologists in their favouritism of Clinical Psychologists, I will not be renewing my membership with them. I have been a registered Psychologist since for 13 years. I have worked both in private practice and also for organisations NGO's, and Universities.

As a registered Psychologist, I represent 70% of the population of Psychologists. Clinical Psychologists represent 30% of the industry. To my dismay, there have been ruptures within the industry over the years. The Australian Psychological Society (APS) argue for higher rebates for services offered by a clinical Psychologist. Economically, this seems senseless as there is no evidence to suggest that there are improved outcomes for consumers serviced by Clinical Psychologists. In fact, evidence suggests that there is no statistical difference in outcomes between Registered and Clinical Psychologists:

https://reformaps.org/second-evaluation-of-the-pirkis-et-al-2011-study/

The APS Green Paper

The APS has recently released a Green Paper as part of the Medicare Benefits Schedule (MBS) review. The recommendations propose a 3-tiered system such as a Stepped care model. There is no evidence supporting such a model as being effective in the provision of mental health services to the public. I work in Lismore and used to work in a team of both Clinical and Registered Psychologists and there was no difference in the outcomes for clients based on whether we were clinical or registered psychologists.The Current Green paper suggested by the APS would only make the waiting list in my rural area longer, it is already about 3 months! There are many more registered psychologists in Lismore and surrounds than there are clinical psychologists and all are trained to treat mild- severe cases. The insinuation that general psychologists are not, is backed by no clinical evidence and will only increase waiting times for consumers.

I recently attended a Black Dog training day for depression in rural areas. BEACH (Bettering the Evaluation and Care of Health Program) estimated that 13% of GP encounters were mental health related in 2013 and 2014. And the National Survey of Mental Health and Wellbeing (NSMHWB) of adults estimated that 20% of the population experienced a common mental disorder. In rural areas depression rates and suicide rates are also known to be higher. The recommendation from the Green Paper is that consumers be classified by a Doctor as having either 'mild', 'moderate' or 'severe' mental health conditions, and that Medicare rebates depend on these classifications. This suggests that Psychologists like myself who have been providing care in rural areas need further training to do what they are already doing. It's like asking a GP to do more training to be a GP. It makes no professional sense, and my experience of working with GP's is that they see us as the

experts in mental health therapy, they are the experts with medications.We work together. The Green Paper proposed by the APS seeks to send consumers on a merry go round of treatment, to the GP then the psychologist, then the GP then depending on the severity to yet another Psychologist. This is a convoluted system which will only serve to confuse clients further. Most of my clients don't know the difference between a Psychologist and a Psychiatrist, let alone a Psychologist and a Clinical Psychologist. The three tiered system will not work and will only serve to confuse an already vulnerable population.It is not a recommendation that would be accepted for any physical health, condition, so why should it be applied to people with mental health conditions? What about suicidal clients, the wait list in lismore is long enough - the green paper would only increase wait times for vulnerable consumers. It also limits the consumer's access to only 30% of the industry. The risks are long waitlists, increased travel time for the consumer, as the majority of Clinical Psychologists work in urban areas, and decreased access to the most vulnerable consumers. This recommendation also reduces client choice in practitioner and presents a complex and confusing model to the most vulnerable consumers to navigate. This is disruptive, inefficient and for those consumers managing trauma or issues with functioning, highly risky.

Consumer Choice

There seems to be a preference among the public for access to single Practitioners as opposed to services. The preference seems to be driven by the desire, as reported by clients, to engage in personalised, non-intimidating and relationship based services from private practising Psychologists. There is a reported desire among my practice members not to have to recount their experiences to several practitioners in order to seek treatment. The benefit of private practise Psychologists are that consumers have choice about who they engage with, that speciality/ niche competencies can be offered, and that the therapeutic environments can be confidential. Larger services have other consumers in waiting rooms, admin staff, other practitioners, and service workers in attendance, which offers a challenging environment to those with anxiety disorders and trauma-and-stressor related disorders.

Centrelink

Consumers will no longer have reports accepted written by Registered Psychologists to support access to the Disability Pension or relevant services. The cost & impact comes to the consumer. It is fair to assess that a person applying for a Disability pension or relevant services with Centrelink is more likely to present with difficulties in functioning, vulnerabilities and risks. It is fair to assume that a person with this presentation is more likely to be impacted by mental health issues, either as the primary condition, or secondary to a physical health condition. Therefore, the burden is increased for the consumer to have to find and engage a Clinical Psychologist (only representing 30% of the industry therefore less accessible), in order to get access to a report to support their cause with Centrelink. In some cases, this has meant that a consumer engaged with a Registered Psychologist has had to also engage a Clinical Psychologist for the sole purpose of reporting to Centrelink, be referred on and dis-engage from preferred practitioner, or not achieve this tasks at all, placing them at increased vulnerability as they aren't able to access the necessary assistance from Centrelink.

Mental Health Funding

Funding for mental health attracts a very small portion of Federal funding for health, and yet mental health conditions are high in prevalence among the Australian public. I have read that increased spending assumes that the current system is failing. However, it is important to note that Depression

alone costs the economy $14.9 Billion Dollars.Whilst I support the need to review mental health servicing, I encourage Commissioners to consider psycho-social factors behind increased need for mental health service spending and the cost to the Australian public if mental health goes untreated. See research article link Below;

Cost of high prevalence mental disorders: Findings from the 2007 Australian National Survey of Mental Health and Wellbeing. *Australian and New Zealand Journal of Psychiatry.*
Yu-Chen Lee, Mary Lou Chatterton, Anne Magnus, Mohammadreza Mohebbi, Long Khanh-Dao Le, Cathrine Mihalopoulos
First Published June 1, 2017

https://journals.sagepub.com/doi/abs/10.1177/0004867417710730

Psychiatrists

During my years in psychological practice, there have been numerous instances where I have recommended the involvement of a Psychiatrist to the client. I have offered this by providing a list of names of local Psychiatrists and suggestion that the client schedule an appointment with the G.P. and seek their opinion, referral suggestions and referral letter. Each time the client has been willing. On numerous occasions the client has returned for further sessions with me, as planned, and advised that they met with the Psychiatrist and offered me consent for me to share information with treating Psychiatrist. From this point onwards, I cc the Psychiatrist at each 6th session and 10th session report (as per the mental health care plan) and share any relevant correspondence about the client. If necessary I make phone calls of offer myself for a case consultation. It has been my experience that the communication received from the treating Psychiatrists has been very poor. I am not included in their reports to the G.P. and the liaison is almost non-existent from their end. I support recommendations that Psychiatrists be instructed to liaise and share information with the treating Psychologist when clients have given consent to do so. On two occasions, when I have successfully secured a case consultation with a Psychiatrist and G.P., with the only Psychiatrist I have ever liaised with willing to do so, I have offered my time free of charge while the G.P. and the Psychiatrist have been able bill for the case consultation on the Medicare benefits schedule. There is no such item for a Psychologist. I support recommendations made that Psychologists be able to charge the MBS for such case consultations.

My understanding is that there have been prominent Psychiatrists sharing criticism of the Better Access Scheme. Whilst there are aspects of the scheme that need to be reviewed, I refute comments made that one risk of the scheme is that Psychologists might use methodologies that are not evidence-based, as long as Psychologists maintain their qualification. Psychologists abide by a strict code of ethics, it is in our training, whichever pathway has been taken, that we learn to apply evidence-based methodologies. It is by our engagement in continuous professional development (necessary to maintain our qualification) that we continue to evaluate and update our practices to be evidence-based.

Diagnosis
When a patient is referred by a Doctor on a Mental Health Care Plan (MHCP), they are classified as having a mental health condition in order to be eligible for the MHCP. This ‘diagnosis’ is then on their medical record. However, there are times, that the medical doctor has not been able to offer the correct diagnosis. This could be for a number of reasons:
- The consult was not long enough to conduct a thorough assessment
- The doctor has limited training in mental health

- The patient has not yet established a therapeutic rapport to disclose all of the information necessary for the correct diagnosis

A psychologist, will usually many sessions before a diagnosis is made. There are significant implications for a person's future insurance policies when diagnoses are on their medical records. Therefore, I recommend that measures are put in place to limit the possibility of false diagnoses to be placed on a patient's medical record prior to the consumer having even met with a mental health professional.

Review processes

I refute claims made that there are no review processes in place for private practising Psychologists when working within the Better Access Scheme. When a consumer is referred on a Mental Health Care Plan (MHCP) by a General Practitioner (G.P.), they are typically referred to a Psychologist known to that G.P. as offering evidence-based interventions. Typically, a relationship has already been established between the G.P. and the Psychologist by working collaboratively to care for a patient's mental health needs. The G.P. typically has some knowledge of what the Psychologist offers in terms of interventions, their specialities and prior successes of previous patients referred. A consumer is referred by the G.P. for 6 sessions initially on the MHCP, once those are used by the consumer, and more sessions are required, a is written by the Psychologist to the G.P. detailing the assessment, the treatment, progress made and recommendations for future management. The consumer must then schedule a review appointment with the G.P. and may be asked a series of questions to review the progress and engagement with the Psychologist in order to determine whether further sessions are approved. Psychologists typically use Outcome measure, the type depends on the client's presentation, as part of the reporting to the G.P. Outcome measures can include:

- DASS-21
- K10
- GAD-7
- PHQ-9
- SDQ
- DES-II etc.

I appreciate the opportunity to provide feedback to the Commission. Thank you for your work and I wish you all the best as you seek the best possible outcomes for the Australian public.

Sincerely,