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Submission to The Mental Health and Suicide Inquiry

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I write to encourage the inquiry to question some of the existing assumptions inherent in the workforce for mental health in Australia and support the vast majority of psychologists in Australia delivering the highest standards of mental health care. Australia has one of the best mental health systems in the world (though of course it can always be improved) and it is in no small part due to the staff within it.

I would also like to support the statements made by the deeply respected Dr Michael Carr-Gregg in support of ending the two-tier medicare rebate system for psychologists in Australia, as there is no scientific evidence to support it (Nyman et al 2010; Probst et al 1994; Pirkis et al 2011).

In summary, the current endorsement and training systems for psychology in Australia are simply unsustainable for a small population and, without change, will result in a drastic shortfall between need and supply of psychological services, endangering lives.

In essence then:

1. Please create a one-tier only Medicare rebate for all clients of all registered psychologists in Australia and raise the Medicare rebate to $150 per session to allow for greater access, to facilitate more bulk billing, and to enable appropriate treatment rather than an inadequate psychological health care response.

2. Cease discrimination of psychologists without clinical endorsement in areas including but not limited to employment opportunities, scope of practice and funding. This is becoming more commonplace and if allowed to continue will mean a drastic shortfall of staff to mental health services in Australia.

If competence of psychologists is the core of this issue then a behavioural standard should be implemented (such as Fouad et al 2009) where ALL psychologists can show competence using behavioural indicators developed to be demonstrated in multiple training and assessment methods, not just University courses which discriminate against those who are older, and hence did their honours year more than 10 years ago. University courses are also severely limited in the numbers they can take and are also staffed largely by non-practitioners who may not be able to fulfil the behavioural standards themselves. Hence, if the object of the endorsements is to encourage psychologists to “up-skill” then it should be possible for ALL psychologists to undertake the progression of their skills when they have the means and time – it cannot be limited by access to a single type of University course with questionable outcomes and age-ist biases.

In addition, the bias towards one particular masters course for preferential treatment means that psychologists with more advanced qualifications such as PhD or multiple Masters degrees including other psychological masters degrees cannot progress, making the qualification and training programs a nonsense. I am one of these psychologists with a PhD in science, and 3 Masters degrees including one in psychology, I am technically MORE qualified than someone with a single Masters

degree in clinical psychology, but the training and qualification program in Australia preferences the lesser educated. This is a nonsense and makes us an international laughing stock.

3. Include Medicare rebated assessments funded at a sufficient level so that these practitioners, too, can provide bulkbilling services without endangering the sustainability of their practices.

4. Prioritise key prevention and early intervention settings such as schools and workplaces by supporting the existing work that is being done by psychologists in these spaces through grants and other support mechanisms. In addition, fund a dedicated preventative/early intervention psychology workforce so that this area has sufficient staffing to keep progress.

5. Instate permanent universal telehealth so that distance (a perennial Australian problem), or able-ness is no longer a barrier to getting help.

6. Implement the Productivity Commission recommendation for up to 40 MBS rebated sessions per annum. The data science behind this recommendation is exceptional.

7. Encourage therapy first, medication second with GP's discretion when symptoms are severe.

8. Simplify the process of accessing a psychologist. This includes simplifying referrals, reviews, letters back to referrers, and upgrading the MBS to reduce the burden on psychologists. Psychologists should also not be held financially accountable for referral errors by medical practitioners, which also leads to psychological practices being financially unsustainable, in essence the burden of administration needs to be drastically reduced.

9. Broaden MBS rebatable sessions to psychologists to incorporate vital prevention and early intervention strategies in addition to responding to mental illness as well as couples counselling and family therapy as social support is a central aspect of mental health.

10. Re-instatement of self-referral processes integral for client's sense of autonomy, important for psychological recovery, to increase access to psychological services. In this model, the psychologist is once again, as had been in earlier times, relied upon to liaise and communicate with the client's treating medical practitioner/s as appropriate and as per the privacy and informed consent legislations. This is where psychologists would prefer to spend their time and can do so if the burden of administration is reduced.

11. Establish a 'Provisional Psychologist' Medicare rebate to boost the psychology workforce, increase access to mental health and provide reliable income for both employers and early career psychologists.

12. Develop incentives for rural and remote psychologists- similar to GP's so that it is possible to get face to face sessions in the bush if people want it.

13. Expand the evidence-based approaches able to be used by psychologists to allow the clinician to use any technique that has adequate Level I, Level II or in some specific conditions Level III evidence. Psychologists are trained in evaluating the evidence base for the use of therapeutic techniques and need to have the freedom to choose the best approach for each client independently rather than have restrictions on their treatment.

14. Review the increasing trend toward mental health "hubs". These hubs are inefficient and audits have shown they are ineffective, they also only treat a small range of mental illness (Hifferty et al 2015; Jorm et al 2020). They require a lot of funding to establish and maintain, generally have high staff turnover due to low financial renumeration for providers due to their reliance on bulk billed

Medicare rebates for practitioners and often do not facilitate access to mental health services to those with disabilities, transport issues, or reside a distance away from the facility. Adequately funding the Medicare system to allow clients to choose a mental health clinician in their local area is the most cost effective and easily implemented strategy.

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