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4<sup>th</sup> August, 2011  
Attention: Committee Secretary  
Senate Standing Committees on Community Affairs  
PO Box 6100  
Parliament House  
Canberra ACT 2600  
Australia

**Re: Senate Submission for Senate Inquiry into Commonwealth Funding and Administration of Mental Health Services in Australia.**

### **My Background**

I am a Clinical Psychologist with a doctoral degree in clinical psychology. I currently work full-time in private practice and have previously worked as a psychologist in the public sector. Prior to being registered as a psychologist, I worked in organisational development within the public healthcare sector for 10 years.

### **Terms of Reference Addressed in this Submission**

My submission relates to the following Terms of Reference (TOR) for the Senate inquiry into the *Commonwealth Funding and Administration of Mental Health Services in Australia*:

- Changes to the Better Access Initiative including the rationalisation of allied health treatment sessions (TOR (b)(i)), and the impact of changes to the number of allied mental health treatment services for patients with mild or moderate mental illness under the Medicare Benefits Schedule (TOR (b)(iii)); and
- Mental health workforce issues, including the two-tiered Medicare rebate system for psychologists (TOR (e)(i)).

## Concerns Regarding Changes to the Better Access Initiative

### Benefits Associated with *Better Access Initiative*

Results from the government-commissioned evaluation of the *Better Access Initiative* provided preliminary support for the effectiveness of the *Better Access Initiative*. For example, the report found that the *Better Access Initiative*:

- is providing good value for money;
- has positively effected Australian mental health workforce operations, including increased collaborative care;
- has improved access to and outcomes from primary mental health care for people with moderate to severe common mental disorders;
- has reached all socioeconomic groups, especially those who have historically been most disadvantaged; and
- is achieving positive outcomes for consumers, in terms of reduced psychological distress levels

Source: *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Scheme Initiative: Summative Evaluation, Final Report*

Given these positive preliminary findings it would seem logical for the government to continue the *Better Access Initiative* in its current form and undertake a more comprehensive and methodologically rigorous evaluation of the initiative to better understand the reasons for these positive outcomes and to ascertain the longer-term outcomes of the initiative. Instead, in the 2011-2012 Federal Budget, the Australian Government announced plans to 'rationalise' the Better Access Initiative, including a reduction in the maximum number of psychology treatment sessions consumers with recognised mental illness can access in a calendar year from 18 to 10.

### The Government's Rationale for Cutting the Better Access Initiative

According to the Federal Government,

*"The new arrangements will ensure that the Better Access Initiative is more efficient and better targeted by limiting the number of services that patients with mild or moderate mental illness can receive, while patients with advanced mental illness are*

*provided with more appropriate treatment through programs such as the Government's Access to Allied Psychological Services program.*", Source: Federal Government 2010-2011 Budget Paper No. 2 [http://www.budget.gov.au/2011-12/content/bp2/html/bp2\\_expense-12.htm](http://www.budget.gov.au/2011-12/content/bp2/html/bp2_expense-12.htm).

In addition, the Department of Health and Ageing Fact Sheet on the Budget measure states that,

*"People with severe and persistent mental disorders who require over 10 allied mental health services are still eligible for up to 50 Medicare Benefits Schedule consultant psychiatrist services per annum, or to access the specialised mental health system in each State or Territory."* Source: Australian Government Budget Paper No. 2

### **Problems with the Government's Rationale for Cutting Better Access**

The abovementioned statements made the government are problematic in several ways. Firstly, the statements imply that, in the government's mind, the provision of up to 18 psychological treatment sessions to consumers with a mental health disorder under the Better Access Initiative is somehow inefficient and ill-targeted.

Secondly, the statements imply that consumers of psychological treatment under the Better Access Initiative experience only mild to moderate levels of mental illness. The view that the *Better Access Initiative* in its current form is somehow inefficient, ill-targeted, or only accessed by consumers with mild or moderate levels of mental illness directly contradicts findings from the review of the Better Access Initiative, a review which the government itself commissioned!

Thirdly, the statements imply that there are more accessible, efficient and appropriate government-funded service alternatives available to individuals who have been diagnosed with 'advanced mental illnesses'. For reasons outlined below, it is misleading for the government to suggest that such alternatives exist.

Arguments that support the maintenance of the *Better Access Initiative* in its current form and argue against substituting the *Better Access Initiative* with alternative primary care or public health service options are outlined below. These arguments include the risks to consumers of cutting the Better Access Initiative, problems with supposed alternatives to the *Better Access Initiative*, and flawed rationale for making changes to the initiative.

## **Loss of 'Exceptional Circumstances' Poses Risks to Consumers**

Currently, within a calendar year, consumers with a recognised mental disorder can be referred by their GP for 12 sessions of psychological treatment under the Better Access Initiative, and, under the 'exceptional circumstances' provision of the Better Access Initiative can be referred for an additional six psychological treatment sessions.

The ability of consumers to access these additional psychological treatment sessions under exceptional circumstances provides an important safety net for consumers. It means that consumers can receive a course of psychological treatment (of up to 12 sessions) and know that they can access further treatment with the same psychologist if they:

- experience significant symptom exacerbation after treatment ends
- suffer secondary mental health problems following treatment of a primary mental disorder (e.g. primary substance abuse is resolved and previously masked panic attacks need to be addressed)
- are faced with significant changes to their circumstances that put them at risk of, or precipitate actual relapse (e.g. become pregnant, go through divorce, suffer job loss, are diagnosed with a major health problem, etc).

Removal of the 'exceptional circumstances' provision by the government removes this safety net for consumers and places them at increased risk of mental illness problems.

## **Problems with Alternatives to Better Access**

The government has argued that consumers with mental illness need not be concerned about the loss of this safety net because alternatives are in place, namely:

- a private psychiatrist;
- the Access to Allied Psychological Services program (ATAPS);
- 'the specialised mental health system in each State or Territory the public health system (i.e., the public health system); and / or,
- new government programs, which do not yet exist.

However, as argued below, these alternatives do not, in reality, offer an alternative safety net for vulnerable consumers and do not justify the government's planned cuts to the *Better Access Initiative*.

### Limitations of Private Psychiatrists

The government has stated that consumers with recognised mental disorders who have exhausted their psychological treatment sessions under the Better Access Initiative will not miss out on mental health treatment because they are eligible to access a large number of psychiatric treatment sessions under the Medical Benefits Schedule. Unfortunately, while consumers may be *eligible* to access extensive psychiatric treatment under the Medical Benefits Schedule, in reality, it is often the case that they cannot *actually* gain access to psychiatrists (certainly not as readily as they could their psychologist). There are two key reasons for this. Firstly, compared with psychologists' fees, for many consumers, psychiatrists' fees are prohibitively expensive (gaps of up to \$200 must be paid to see a private psychiatrist). Secondly, because of the absolute and chronic shortage of psychiatrists worldwide, the waiting lists to see a psychiatrist privately are significantly longer than for psychologists.

Surely (unless the consumer actually needs psychiatric treatment), if a psychologist can effectively treat a consumer for a lower cost, within a shorter time frame (due to greater accessibility), there is little justification for reducing the consumers' access to psychological treatment and increasing the burden on already heavily burdened psychiatrists.

The idea of sending a consumer to a psychiatrist if they have a relapse or crisis, or if their limited-in-duration psychological treatment was simply insufficient to achieve a full recovery also implies that psychologists are trained to treat only simple or mild mental disorders and psychiatrists are only trained to treat more severe or complex mental disorders. This idea fails to recognise that psychologists and psychiatrists are qualitatively distinct professions who are trained to provide different but related and complementary clinical treatment to consumers with mental health disorders at all stages of treatment and at all levels of clinical severity across a range of settings.

### Problems with ATAPS

ATAPS is a relatively expensive, administratively burdensome alternative psychological service option for consumers who have exhausted psychology treatment under the Better Access Initiative. In particular, the aforementioned evaluation of the Better Access Initiative showed that the typical cost of a package of care delivered by a psychologist under the initiative was \$753.00. In contrast, ATAPS has been found to cost 2-10 times more per session to administer than the Better Access Initiative (Source: Outcomes and proposed next steps: Review of the Access to Allied

Psychological Services Component of the Better Outcomes in Mental Health Care Program, 2010. Department of Health and Ageing). Also, compared with the Better Access Initiative, the ATAPS program places a greater administrative burden on GPs, who are already heavily burdened with administrative tasks and could be better using their time to treat other patients. (This is perhaps why GPs supported the implementation of the fee-for-service model under Better Access Initiative rather than ATAPS prior to Better Access being implemented in 2006).

Furthermore, ATAPS utilises a team-care model. While the bulk of consumers who participate in the Better Access Initiative have moderate to severe mental illness, they do not necessarily need team-based care. For these consumers, it would be wasteful to develop and implement a team-based treatment plan that is not necessary for them. Finally, because the Better Access Initiative involves a fee-for-service model, it enables clinicians to receive payment for services as they are provided to consumers. In contrast, the ATAPS funding model, which does not allow clinicians to be paid until blocks of treatment have been completed, makes it difficult for clinicians to maintain a cash flow to support their private practice.

#### The Overburdened Public Health System

As a third option, the government has proposed that consumers access the public health system for psychological treatment if they have advanced mental illness and can no longer obtain services under the Better Access Initiative. Anyone who works in healthcare, or has tried to access the public mental health system knows that the public system is grossly under-resourced and consequently, is only accessible to the most severe *and* acutely mentally ill consumers. Increasing demand on an already overburdened public mental health system, or assuming that the small amount of funding the government promises to inject into the public system will enable the public system to service the mental health needs of consumers who are unable to access treatment under Better Access or other primary care programs is ludicrous. Also, as with the ATAPS program, provision of team-based care under the public health system for people with mental illness is often not required and would be a wasteful allocation of public health services.

#### Promises to Reallocate Funding to New Programs

The government has justified cuts to psychological treatment under the Better Access Initiative based on *promised* increases in funding to the public sector and other mental health intervention programs. However, the government has misrepresented its

funding promise here. In particular, the government has stated that it will cut \$580 million from its existing mental health programs (primarily the Better Access Initiative), and has only allocated an additional \$47 million for mental health programs.

In any case, any increased funding that has been promised for mental health programs has not yet been allocated, and will be allocated across several years. Hence, it will take some time for the cuts to the Better Access Initiative to translate into programs that consumers can actually access. (This is assuming of course that the government maintains office long enough to see the cuts to Better Access actually translate into new programs for the public mental health sector). In the absence of accessible psychiatrists and an already overburdened public healthcare system, can the minister explain where clients will go for support if needed in the meantime? Perhaps back to their GP for an administratively burdensome and expensive referral to ATAPS?

#### Problems with All Alternatives to Better Access

Requiring consumers to change service providers and engage in a new program to obtain ongoing psychological treatment fails to provide the consumer with continuity of care. Continuity of care is particularly important for the consumer, who at a high risk time is at greatest need of a secure, familiar face who is aware of their history, risk profile and treatment preferences. However, if the government implements cuts the 'exceptional circumstances' provision of the Better Access Initiative, these are the consumers who will be most likely to suffer discontinuity of care and consequently, at greatest risk of further deterioration in their mental health.

Requiring consumers to change service providers and engage in new mental health program to obtain treatments is also onerous for the clinicians who have already treated a consumer under the Better Access Initiative and for any clinicians delivering additional services under any new program. For example, clinicians administering new services will need to reassess the client, build rapport all over again, and liaise with the original treating psychologist and GP to ensure continuity of care. Furthermore, given access problems with psychiatrists and the public health systems, it is possible that a consumer with a mental health disorder who is at high risk may simply not be able to access an alternative service, which places them at even greater risk of harm to themselves or others.

Overall then, although the government's own commissioned report provides preliminary evidence that the psychological treatment provided to consumers with mental disorders under the Better Access Initiative represents 'good value for money',

the government plans to reduce its investment in the Better Access Initiative and offer as alternatives, services that have been shown to be relatively expensive (for both the government and consumers), fail to provide continuity of care, place an unnecessary burden on clinical services that are in chronic short supply, are more difficult for consumers to access, or, do not exist yet! Please explain!!?

### **Flawed Rationale for Changes to Better Access Initiative: Reliance on Medians**

The government's decision to reduce the number of psychological treatment sessions accessible to consumers under Better Access from 18 to 10 appears to be (at least partially) based on a review of MBS items, which found that

- consumers utilised a median of five psychological treatment sessions under the Better Access Initiative in 2008; and
- the majority of consumers utilising the Better Access Initiative in 2008 did not access all of the 12, or, in 'exceptional circumstances', 18 psychological treatment sessions available to them under the Better Access Initiative

Source: *Evaluation of the Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Scheme Initiative, 2010.*

The government's reliance on the median service utilisation rates of a relatively new initiative seems a highly unsophisticated, one-size-fits-all method for estimating psychological treatment duration needs for consumers with mental disorders. Instead, the government should, at the very least, take into account existing guidelines and empirical research regarding psychological treatment needs for various mental disorders. The government should also seek to better understand Better Access utilisation patterns. These issues are expanded on below.

### **The Need to Consider National and International Guidelines**

In determining the optimal number of psychological treatment sessions required by consumers, policy makers should look to existing National and International Guidelines. If the government did this, they would see that ten psychological treatment sessions is insufficient for the treatment of common mental disorders. By way of example, three sets of published guidelines are provided here.

1). The National Clinical Practice Guidelines as established by NICE (National Institute Clinical Excellence, UK; 2005) recommends the number of psychological treatment sessions for various commonly diagnosable mental health disorders including:



- Posttraumatic Stress Disorder = 8-12 sessions (p. 63-64; NICE National Practice Guideline No. 26)
- Generalised Anxiety Disorder = 12-15 sessions (p.17; NICE Clinical Guideline 113)
- Panic Disorder = 7-14 sessions (p.29; NICE Clinical Guideline 113)
- Major Depressive Disorder = 16-20 sessions (p.28-29; NICE Clinical Guideline 23)

Within the NICE guidelines, it is acknowledged that these recommended treatment session numbers pertain to the application of specific clinical interventions (e.g. exposure therapy for PTSD) and that additional sessions are required for such things as assessment, rapport building, and management of comorbid conditions, especially when conditions are chronic.

2). In 2009, the Australian Centre for Posttraumatic Mental Health and Rural Health released Guidelines for the treatment of Simple PTSD, which recommended 8-12 sessions. For more complex PTSD presentations (i.e., several problems arising from multiple traumatic events, traumatic bereavement, or where PTSD is chronic and associated with significant disability and comorbidity) further sessions using specific treatments are recommended to address problems.

3). In 2010, the Australian Psychological Society (APS) conducted a literature review to determine treatment session durations required for various mental disorders. Based on this review, the APS recommends treatment durations of up to 52 sessions per year for various mental health disorders, including:

- Adjustment Disorder = 14 sessions
- Eating Disorders = 15-20 sessions
- Phobic Disorders = 12 sessions
- Generalised Anxiety Disorder = 14 sessions
- Panic Disorder = 7-14 sessions
- Obsessive-Compulsive Disorder = 12 sessions
- Major Depressive Disorder = 16 sessions
- Drug and/or Alcohol Disorders = 52 sessions

The National and International Guidelines referred to above are based on extensive reviews of existing empirical data. Unfortunately, the proposed changes to Better Access Initiative disregards these guidelines and instead relies on a median service utilisation score to determine psychological treatment requirements for consumers with diagnosed mental disorders. What ever happened to evidence-based policy making.

The government has certainly relied on scientific evidence to justify other policy decisions and initiatives, such as pricing carbon. Why not rely on it to inform mental health policy directions and funding decisions?

#### Need to Consider Reasons for Better Access Utilisation Patterns

Policy makers should also consider the reasons for consumers' varying levels of utilisation of the Better Access Initiative. At the most basic level, rather than using median utilisation levels to dictate future investment levels, in determining optimal treatment numbers required, the government should seek to understand the reasons for which consumers participated in a median of five psychological treatment sessions. For example, attempts should be made to explain key reasons for which consumers discontinued psychological treatment before the maximum number of treatment sessions available under the Better Access Initiative were exhausted. Obviously, finishing therapy doesn't necessarily mean treatment outcomes have been achieved. Reasons for discontinuation could be due to a range of factors such as

- perceived lack of treatment gains;
- lack of ability by consumer to pay gap fees;
- mental illness severity level – it may be that more severely mentally ill (rather than mild to moderately ill) consumers engage less well in the Better Access Initiative;
- time of year of referral – consumers referred near the end of a calendar year can access fewer sessions but may not be finished treatment.

#### **Unfounded Assumption: Better Access is for Mild to Moderate Mental Illness**

The government's decision to reduce its investment in the Better Access Initiative appears to have been partially predicated on the assumption that consumers treated by psychologists under the Better Access Initiative experience only mild to moderate mental illness. This assumption is simply not borne out by the government's own commissioned report which found that:

- of consumers who participated in a review of the Better Access Initiative and were seen by a clinical or Registered Psychologist, at least 83% had a 'high' or 'very high' level of psychological distress

Source: the *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Scheme Initiative: Summative Evaluation, Final Report*, p.35.

The assumption is also contradicted by the Australian Psychological Society (2011) independent review of treatment provided by psychologists under the Better Access Initiative, which found that:

- 84% of 9900 consumers who participated in between 11 to 18 psychological treatment sessions under the Better Access Initiative, had a moderate to severe or severe disorder, and that 43% had further complexities such including a second mental illness, personality disorder or substance abused.

Furthermore, there are no guidelines or standards pertaining to the utilisation of the Better Access Initiative based on the severity of the consumer's mental illness. As such, it is difficult to know how the government arrived at this view. This view certainly runs contrary to the original intention of the Better Access Initiative. In particular, when the Better Access Initiative was established, the government of the day stated that its intention was to, "*provide clinical services to people with mild, moderate and severe mental illness, including early identification, assessment, continuous care and case management*". (Source: National Action Plan on Mental Health (2006-2011). Council of Australian Governments (COAG) (2006). p.14). Consistent with the original intention of the Better Access Initiative, the government- commissioned evaluation of the '*Better Access Initiative*' in its current form has been found to be a cost-effective way of delivering effective mental health care to individuals with mild, and (more commonly) moderate to severe mental illness.

Even if some of the consumers who utilise psychological treatment under the Better Access Initiative are categorised as having mild or moderate mental illness, does this mean we should not treat them, or that these consumers need only 10 treatment sessions? Empirical evidence and associated National and International Guidelines simply do not support the provision of such a limited level of psychological intervention even for mild and moderate mental illness. Doesn't the removal of services to consumers with mild or moderate mental illness run contrary to the government's own agenda for mental health in the 2011-2012 budget – which is to increase preventative and early intervention measures for mental health disorders? A lot of funding has been planned for preventative measures for younger adults (e.g. via proposed funding to Head Space). However, prevention and early intervention for younger adults should not be provided at the expense of already operating and effective interventions (such as the Better Access Initiative), that can target individuals of all age groups.

## **Consumers Lose, Not Psychologists**

There have been anecdotal remarks made by politicians and various interest groups that psychologists who want to maintain the Better Access Initiative in its current form are doing so out of self interest. I have not seen any evidence for this.

Instead, the Better Access evaluation finding that only five percent of consumers are accessing the full 18 sessions of psychological treatment available to them in a calendar year provides some evidence that psychologists are not simply milking clients for as many treatment sessions as possible. Instead, this finding suggests that psychologists are utilising the Better Access Initiative current system appropriately and frugally. (Although, as noted above, various explanations for treatment utilisation rates under the Better Access Initiative need consideration before drawing any conclusions).

In addition, the fact that all psychologists working in private practice (that I know at least) have waiting lists indicates that psychologists will continue to get sufficient referrals to maintain their practice regardless of whether consumers can access 10, 12 or 18 sessions of psychological treatment under the Better Access Initiative. In other words, it is not the psychologists who will suffer as a result of these changes; it is the consumer. While these points indicate a lack of self-interest by psychologists, I am not sure of any contrary evidence to support the idea that psychologists who are fighting against cuts the Better Access Initiative are doing it out of self-interest.

## **Summary and Recommendations Regarding the Better Access Initiative**

In summary, I acknowledge the need of the Department of Health and Ageing to deliver appropriately targeted and cost-effective mental healthcare services to Australians. To this end, I support the government's expansion of any existing mental health care programs that have demonstrated efficacy and for the implementation of any new mental health care programs that promise to be support Australians with mental illness and their loved ones.

Based on preliminary evaluation data, it appears that the Better Access Initiative is a well-targeted, clinically effective, accessible and cost-effective initiative for treating consumers with recognised mental disorders. As such, there appears to be little justification at this stage for reducing its scope. Neither is there good justification for reallocating funding from this initiative into other less cost-effective, harder to access

and / or yet-to-be established and tested initiatives. Instead, the evidence to date suggests the need to more comprehensively investigate the mechanisms by which the Better Access Initiative has achieved its apparent success to date, with a view to enhancing this already-established, accessible and cost-effective initiative.

Rather than cutting the number of psychological sessions available to consumers with a mental disorder under the '*Better Access Initiative*', I request that the following be considered:

- Firstly, that a more methodologically-rigorous review of the current 'Better Access' data be conducted to better identify the number of psychological sessions required to achieve desired treatment outcomes. Such a review would take into account the array of complexities and severities associated with the assessment, diagnosis and treatment of different recognised mental health disorders.
- Secondly, that empirical recommendations already encapsulated in National and International Guidelines (as mentioned above) be utilised for the determination of the level of psychological intervention and number of psychological treatment sessions required to achieve desired treatment outcomes.
- Thirdly, that the government apply a participative decision making model, which includes a more substantial representation of Clinical Psychologist and general practitioners from both the private and public sectors, to determine the model and extent of funding it will apply for the provision of mental health services at the primary care level.

## **Concerns About the Review of the Two-Tiered Medicare Rebate System**

### **Why is the Two-Tiered Medicare System Under Review?**

The TOR for the *Commonwealth Funding and Administration of Mental Health Services in Australia* inquiry includes (e)(i) Mental Health workforce issues and the two-tiered Medicare Rebate system for psychologists. It is unclear why the Senate Committee is being asked to consider the two-tiered system for Medicare Rebates, although *Component A* of the aforementioned Evaluation Report provides clues as to why this TOR has been included in the inquiry.

In particular, the evaluation reported on treatment outcomes achieved by Registered Psychologists and Clinical Psychologists separately. Thus, it can be assumed that the Senate Inquiry will be asked to consider whether findings regarding the differences in treatment outcomes achieved by registered and Clinical Psychologists were sufficient to warrant the current differences in Medicare rebates available for these two groups.

In the Better Access evaluation report, the authors note that “Registered Psychologists have contended that they are essentially providing the same services as Clinical Psychologists and should be reimbursed commensurately; Clinical Psychologists have maintained that Registered Psychologists are providing the bulk of services and may not be achieving optimal outcomes for clients....the summative evaluation can only inform these debates in a limited way”. P.46.

For reasons outlined below, it would be inappropriate for the government to rely on findings from the Better Access evaluation report to either

- draw conclusions about differential treatment outcomes that can be achieved by registered and Clinical Psychologists; or
- make changes to the two-tiered Medicare Rebate System for Psychologists.

Also outlined below are factors that should be taken into by the Senate Committee in determining appropriate rebates for mental health services provided by clinical and Registered Psychologists.

### **Limitations of Findings From the Better Access Evaluation Report**

Component A of the Better Access evaluation found that:

- consumers treated by GPs Registered Psychologists and Clinical Psychologists under the Better Access Initiative achieved substantial and positive treatment outcomes
- for both registered and Clinical Psychologists, consumers with higher baseline distress levels (as measured by the K-10) had greater levels of improvement compared with consumers with lower baseline distress levels
- for consumers recruited by Clinical Psychologists, *‘no other factors (besides pre-treatment distress levels) were predictive of levels of gains in K-10 scores’*, p.28
- for consumers recruited by Registered Psychologists, two other variables (treatment completion, and geographical region) predicted levels of gains on K-10 scores.

These findings show that a small group of clinical and Registered Psychologists have been able to demonstrate their ability to deliver effective treatment outcomes for consumers under the Better Access Initiative. The findings also suggest that there *may* be differences in the factors that predict treatment effectiveness across these two professional groups.

However, reliance on these findings to inform policy and funding decisions is problematic for two reasons. Firstly, the authors of the report have deemed the Better Access evaluation findings to be preliminary in nature. Secondly, the report's authors (and reviewers of the report, such as the APS), have cited multiple methodological limitations associated with the evaluation report which render these findings less reliable. For example, the evaluation study was a field study which relied on self-selected psychologists, who self-selected their cases.

If the government plans to rely on mental health treatment outcomes to inform consumer rebate decisions, it should at the very least undertake a more methodologically rigorous investigation of the factors that underlie any differences in treatment outcomes. And if the government plans to rely on differences in mental health treatment outcomes as a function of professional group to inform rebate decisions, shouldn't it include treatment outcomes achieved by all professional groups who are rebated under Medicare including psychiatrists as well as GPs and different types of psychologists?

Rather than relying on preliminary data from methodologically limited field data to determine appropriate Medicare rebate levels for psychologists, the government should take into account the internationally recognised distinction between registered and Clinical Psychologists and follow the standardised practice that operates across all professionals, which is to provide higher levels of remuneration for higher levels of specialisation. Details regarding these points are provided below.

### **Recognition of the Distinction between Clinical and Generalist Psychologists**

The distinction between Clinical and Generalist Psychologists is widely recognised across government, registration and professional bodies, at both a national and international level. For example:

1. The Australian Health Practitioners Regulation Agency (AHPRA), which was established through the Council of Australian Government and is responsible for the implementation of the National Registration and Accreditation Scheme across Australia, recognises the distinction between Generalist and Clinical Psychologists and has established standards and pathways for Registered Psychologists to achieve endorsement in the specialty of Clinical Psychology.

2. The Australian Psychological Society, which is the largest professional body for psychologists in Australia, recognises and supports the distinction between Generalist and Clinical Psychologists. (The APS makes this distinction *despite the fact* that the majority of its members are Generalist rather than specialist Psychologists).

3. The Department of Immigration and Citizenship distinguishes between the skill sets provided by Generalist and Clinical Psychologists. Specifically, this Federal Government Department publishes a Skilled Occupation List (SOL). The SOL *"identifies specialised occupations of high value and includes managerial, professional, associate-professional and trade occupations. The list of occupations reflects the Australian Government's commitment to a skilled migration program that delivers skills in need in Australia. The SOL will continue to deliver a skilled migration program tightly focused on high value skills that will assist in addressing Australia's future skills needs"* (p.1). The current SOL includes both Clinical Psychologists and Generalist Psychologists (which it refers to as 'Psychologist Not Elsewhere Considered'). Source: [http://www.immi.gov.au/media/fact-sheets/24overview\\_skilled.htm](http://www.immi.gov.au/media/fact-sheets/24overview_skilled.htm), Downloaded 13.07.2011.

4. The Australian and New Zealand Standard Classification of Occupations (ANZSCO) recognises the increased specialisation of occupations such as psychology and in recognition of this, classifies Clinical Psychologists as being distinct from Generalist (or 'not elsewhere classified') Psychologists. ANZSCO was developed

*"jointly by the Australian Bureau of Statistics (ABS), Statistics New Zealand (Statistics NZ) and the Australian Government Department of Employment and Workplace Relations (DEWR) to improve the comparability of occupation statistics between the two countries and the rest of the world"*

As acknowledged by ANZSCO,

*"The past decade has seen ongoing structural change in the...labour markets... Occupations have become more specialised and new occupations have emerged and evolved.... ANZSCO (by providing up-to-date occupational classifications) assist(s) enterprises, education and training bodies, government*



*agencies, and industry and professional organisations to understand and adapt to emerging occupational requirements”.*

Source: 1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First and Revised Editions

5. Across most OECD countries, there are recognised differences in the scope of practice suitable to generalist and other specialised psychologists (including Clinical Psychologists). In the main, individuals in OECD countries require a minimum post-graduate qualification in clinical psychology in order to practice in the field of clinical psychology. For examples, see:

- the United Kingdom (<http://www.hpc-uk.org/apply/psychologists/threshold/>),
- the United States and Canada (<http://www.kspope.com/licensing/index.php#US>)
- New Zealand (<http://www.psychologistsboard.org.nz/scopes-of-practice2>)

Given Clinical and Generalist Psychologists are recognised as distinct intra-professional groups worldwide, it is appropriate for the Federal Government to recognise this distinction, and appropriately remunerate psychologists in line with this professional distinction. The government currently does this through the two-tiered Medicare rebate system, differential payments to Registered and Clinical Psychologists within the Department of Veteran Affairs and through its funding of increased places for post-graduate psychology courses (see below) and should continue to do this in the future.

### **Remuneration Reflects Training and Qualification Levels in All Professions**

Across all professions, remuneration levels increase as training, qualification and / or certification levels increase. The increased remuneration levels associated with advanced training, qualifications and / or certification may be market-driven (e.g. the market dictates that Chartered Accountants and Certified Practicing Accountants will be paid more than an individual with a Bachelor Degree in Accounting). Alternatively, these increases are often encapsulated in industrial and enterprise bargaining agreements (e.g. Registered Nurses are paid more than Enrolled Nurses under state awards in Queensland). Other professions within which this *increased training-increased remuneration* relationship applies include the medical, legal, building, engineering and academic professions, to name a few.

Consistent with the *increased training-increased remuneration* relationship that operates worldwide across multiple professions, when the Better Access Initiative was introduced, the government of the day saw it fit to remunerate Clinical Psychologists at a higher level, compared with Generalist Psychologists. Similarly, as of the 1st November, 2010, the Department of Veteran Affairs commenced remuneration of Clinical Psychologists at a higher rate than Generalist Psychologists. For details, see: [http://www.dva.gov.au/SERVICE\\_PROVIDERS/FEE\\_SCHEDULES/Pages/Dental\\_and\\_Allied\\_Health.aspx](http://www.dva.gov.au/SERVICE_PROVIDERS/FEE_SCHEDULES/Pages/Dental_and_Allied_Health.aspx). These decisions were appropriate, in line with market and industrial practices, and reflect the well-recognised intra-professional distinction between Clinical and Generalist Psychologists.

### **Negative Outcomes Arising from the Failure to Value Clinical Psychology**

It is unclear from the Terms of Reference which aspects of the relationship between 'the two-tiered Medicare system' and 'workforce issues' will be considered by the Senate Committee. However, it is reasonable to expect that, if the two-tiered Medicare Rebate System is collapsed and Clinical Psychology rebates are lowered, several negative outcomes will follow.

#### Reduced Access to Specialised Services for Consumers

If Medicare rebates for Clinical Psychologists are lowered, Clinical Psychologists will become less affordable for, and hence less accessible to, consumers. In other words, a reduction in Medicare rebates for Clinical Psychologists would ultimately disadvantage consumers who would have reduced access to a specialised clinical service. This disadvantage would be the greater for the most financially disadvantaged consumers; that is, the consumers of mental health services who the government are supposedly targeting in the 2011-2012 mental healthcare budget!

#### Disincentives to Specialise

Lowering of Medicare rebates for Clinical Psychologists will serve as a disincentive for psychologists to complete post-graduate training programs, which will in turn promote deskilling in the workplace. It is expensive for individuals to undertake specialist training and advance themselves, and financial recompense and incentives are needed. I am sure medical graduates would be less likely to invest in years of extra training to specialise as psychiatrists if their remuneration (eg wages, Medicare rebates) was the same as for GPs providing treatment for mental illness?

### Disincentives to Study Despite Increasing Post Graduate Training Places

The removal of incentives for psychologists to complete post-graduate training would be at odds with the government's increases to post-graduate funding and intentions to up-skill the mental health workforce in Australia. Specifically, in 2006, the Commonwealth Government announced \$103.5 million in funding for additional education places, scholarships and clinical training in Mental Health, purportedly "to increase the supply and quality of the mental health workforce" including "an additional 200 post-graduate psychology places.....as well as 25 full-time and 50 part-time post-graduate scholarships to nurses and psychologists. Mental health competencies and mental health clinical training will be increased across the health workforce, including...psychology..." (Source: Council of Australian Governments (COAG) National Action Plan on Mental Health 2006 – 2011, p.11).

### Failure to Address Workforce Shortages

One of the Department of Immigration and Citizenship goals is to attract overseas-trained professionals to work in Australia in occupations which are considered to be of "high value" but are in short supply in Australia. These occupations include Clinical Psychologists *and* Registered Psychologists. Failure to recognise Clinical Psychologists' specialist skills (eg by removing the two-tiered Medicare System) would make Australia a less attractive place for Clinical Psychologists to work, and is at odds with the Department of Immigration and Citizenship's goal. The removal of the two-tiered Medicare system would also serve as a disincentive for Clinical Psychologists to stay in Australia to work. Which professional group enjoys working in an environment where their specialist skills are not valued and financially recognised?

### Failure to Recognise Expertise

A decision by the Federal Government to lower the Medicare rebate for Clinical Psychologists to that of Generalist Psychologists would be akin to reducing Psychiatrists' Medicare rebates to that of GPs for the provision of mental health-related services to consumers. The decision would simply fail to recognise the degree of training, specialisation and additional accountability that goes with being endorsed as a specialist in a professional field.

### **Assuring Minimum Standards for Clinical Psychologists**

In Australia, there are two pathways individuals can follow to become a Registered Psychologist; 1) via four years of university training plus two years of supervised

practice or, 2) via six or more years of university training plus, which includes supervised practice. However, prior to 2010, there were no clear legislative standards pertaining to the minimum qualification or competency levels that must be achieved by Registered Psychologists in order for them to be certified as specialists in the field of clinical psychology or to assume the title *Clinical Psychologist* in Australia.

In the absence of such legislation and prior to the establishment of AHPRA in 2010, registration boards and professional associations developed their own guidelines and standards regarding the criteria that had to be met before a Registered Psychologist should call him/herself a specialist Clinical Psychologist. As there was no legislation pertaining to the use of different titles for psychologist with different levels of specialisation, Registered Psychologists could ultimately decide for themselves whether they had the competencies required to assume the title of a specialist Clinical Psychologist.

Following the establishment of AHPRA in 2011, national standards for endorsement in specialty areas of psychology were introduced. Under these new requirements Registered Psychologists can only be endorsed to practice in a specialist field of psychology in Australia after they have completed specialised post-graduate training AND supervised practice. In addition, under these new standards, AHPRA regulates the ability of psychologists to assume the title of a specialist psychologist and Registered Psychologists can no longer decide for themselves whether they can use specialist psychology titles such as Clinical Psychologist.

These new requirements are appropriate and in line with international standards for the certification of professionals. In particular, within Australia and many OECD countries, certification of professional competencies by accredited bodies is the standard (and generally only) mechanism for ensuring that an individual enters a recognised profession with a minimum standard of competency. Within professional domains, the accredited bodies include a tertiary university (who oversee an individual's training and obtainment of advanced qualifications) and a registration or licensing body (which then licences, registers, endorses or certifies the individual to practice in the field in which they are qualified).

While any individual could arguably gain competencies to practice in a particular occupation without completing a formal qualification or certification process, the requirement for individuals to complete accredited and advanced training and be

certified as competent by an external authority body before being allowed to practice is critical, because it provides an **assurance** to consumers that that individual is capable of delivering specialised professional services at a minimum level of competency.

This notion of quality assurance is now well-embedded in the healthcare industry. For example, public hospitals cannot operate unless they meet external accreditation standards, such as those stipulated by the ACHS. Medical specialists cannot call themselves a specialist until they have undergone advanced training and been deemed to be competent by external, recognised authorities.

Within psychology, it is recognised that there are many Generalist Psychologists who do not have post-graduate tertiary qualifications, but if tested, would be able to demonstrate the same or higher competency levels than individuals who have completed post-graduate qualifications and relevant supervised practice. However, in order to ensure consumer safety, it is not sufficient for any individual to deem themselves as competent to practice in a specialised field of psychology.

Instead, in the interest of consumer safety, there is a need for all psychologists to actually demonstrate to an independent accreditation authority, through a standardised process, using standardised and endorsed criteria, (such as those developed within the post-graduate training sector) that a set of minimum competency standards have been achieved. In this way, the new national standards (mentioned above) act as an assurance to consumers that a professional entering a specialty area of psychology, possesses a minimum level of competency to practice safely and effectively in their specialty field. In the interests of consumer safety, all Registered Psychologists should accept the need for this assurance process to occur.

In going forward then, the debate should not be about whether or not currently Registered Psychologists should be subjected to a formalised assessment and accreditation process before being deemed a 'specialist' psychologist. Of course psychologists should have to do this. Why? Because consumers have the right to expect that a person providing them with a specialised professional service has been objectively assessed and certified as competent to provide that service.

Instead, the focus should be on identifying the appropriate methods by which to assess the competencies of Registered Psychologists who wish to become Clinical Psychologists. Under the new National Standards, post-graduate university training

and supervised practice are the contexts in which competency assessment occurs. However, as seen in the Vocational Education arena, it would be possible for currently Registered Psychologists wanting endorsement as Clinical Psychologists to demonstrate that they possess specialist competencies via Recognition of Prior Learning and / or Recognition of Current Competencies processes.

Rather than devaluing specialist Clinical Psychologists by collapsing the two-tiered Medicare system, the government should look at alternative ways to certify the competency of currently registered Generalist Psychologists who aspire to assume the title of, and practice as Clinical Psychologists. This approach would maintain the value of existing endorsed Clinical Psychologists and would make it easier for currently Registered Psychologists to demonstrate their clinical competencies and be endorsed as Clinical Psychologists. This would in turn increase the size of the Clinical Psychology workforce in Australia and thereby provide consumers with greater access to an assured pool of specialist mental treatment providers under Medicare.

### **Summary and Recommendations for the Two-Tiered Medicare Rebate System**

In summary, the distinction between Clinical and Generalist psychologists is recognised worldwide and by the Australian Government, and should continue to be recognised through accreditation processes and differing remuneration levels available to these two professional groups. In the interest of public safety, there is a need to ensure individuals who provide specialty professional services in Australia have been deemed competent to do. This need extends to Registered Psychologists who aspire to specialise in the field of clinical psychology. While the current pathway for endorsement as a Clinical Psychologist is post-graduate training, other pathways should be considered for Generalist Psychologists to demonstrate their competency to specialise as a Clinical Psychologist including *Recognition of Prior Learning* and / or *Recognition of Current Competency* evaluation methods applied in the Vocational Education sector.

As such, it is recommended that:

- the Australian Government continues to recognise the distinction between Clinical and Generalist Psychologists by continuing the two-tiered Medicare rebate system
- the Australian Government considers ways in which to assist currently registered (generalist) psychologists to be endorsed as Clinical Psychologists without the need to complete post-graduate tertiary training, e.g., via Recognition of Prior

Learning and / or Recognition of Current Competency evaluation methods. This recommendation applies only to currently registered Generalist Psychologists who became registered as psychologists before the new National Standards for psychologists were introduced and should not apply to individuals currently in training to be registered as psychologists.