Committee Secretary,
Senate Standing Committee on Community Affairs,
PO Box 6100,
Parliament House,
CANBERRA ACT 2600

27th July 2011

Dear Sir or Madam,

RE: Commonwealth Funding and Administration of Mental Health Services

I refer to the current enquiry requested by Senator Fierravanti-Wells and Senator Siewert. I write as the Director of Better Life Psychology and coordinator of the Kelvin Grove Peer Support Netwrok (a group of various psychologists that meet on a regular basis to provide peer supervision for the work that they do), with support from, and on behalf of this group of interested psychologists. These psychologists are both independent and employed and represent 12 psychologists with experience (early career to decades of experience) and qualifications (4+2 to doctoral degrees) across the entire spectrum.

(a) the Government's 2011-12 Budget changes relating to mental health;
This government has successfully acknowledged the need for access to allied health services in area of Mental Health intervention and should be congratulated for the continuing support for people with mental health issues.

(b) changes to the Better Access Initiative, including:
(i) the rationalisation of general practitioner (GP) mental health services,
While there is value in collaborative intervention, and an importance in recognizing the interaction between mental and physical health, the utility of the mental health treatment plan process in the 2710 item is flawed due to a lack of efficacy of these plans. Most Mental Health Treatment Plans received by psychologists require the psychologist to repeat all aspects of the plan in diagnosis and treatment formulation processes. Value for dollar is not inherent in items 2710 requiring a long consultation with the GP and the series of questions that are required for the doctor to complete.

A change in the referral process is appropriate given Paediatricians and Psychiatrists are required simply to write a letter to the treating psychologist. Information often contained in these letters have greater benefit to the treating psychologist than the 2710 process as they give background and relevant information concerning the case in more detail form than the brief items of the 2710.

The utilization of the 2710 item appears to be a bureaucratic measure for triggering the Medicare rebate process rather than a clinical measure for providing greater interaction between professionals. Indeed a shorter consultation with the GP, a measure of need (currently the K10), and a brief note requesting a case formulation and treatment plan from the psychologist would be far more advantageous to the patient. This case formulation stage may require two or three sessions, depending on the complexity of the case and the patient's current circumstances; however these two or three sessions would still be of greater efficacy to the patient and less expensive to the government than the current mental health treatment plan process which required the extended session with a GP and first psychologist session to be devoted to case formulation and treatment planning anyway. The GP could then ratify the treatment plan and treatment could commence. No patient sessions need be required by the GP to ratify the treatment plan. The review would be at the end of the ratified treatment process rather than an arbitrary 6session period.

Executive Summary

* GP Treatment plans do not provide sufficient information to be value for money.

* A simplified referral process will save money while maintaining the Medicare 'trigger'
* Psychologist formulation and treatment plans hold better value for the taxpayer dollar.

(ii) the rationalisation of allied health treatment sessions,

Significant concern exists in regard to the reduction of sessions available to patients with complex needs. While most treatments would be complete within the six sessions framework (2010 Medicare review) the need for extended treatment is necessary for some cases and could be acknowledged through a treatment formulation and planning process, as previously described. The process of GP request for diagnosis and treatment formulation would allow for some clients to benefit from fewer sessions and those requiring more extended intervention to benefit without exceeding a maximum of 18 sessions in the year.

* Some patients have complex needs not able to be met in six to ten sessions.

Patients that have complex needs, especially severely impaired and suicidal patients, are not going to benefit from establishing a therapeutic relationship with a psychologist, only to be required to 'move on' to another service once their 10 sessions are completed. This will create, rather than resolve, underlying psychological issues for that patient. Continuity of care is an essential element in psychological care as the therapeutic relationships is a cornerstone of treatment, unlike physiological care that is somewhat more transferable between clinicians in terms of expected treatment outcomes.

* The therapeutic relationship underpinning treatment is essential.

A review of most treatment protocols in the research indicates that a six session protocol is the minimum rather than the average for treatment. Many protocols in the research literature are based on 12 or more sessions. It is impossible to translate protocols for well researched processes into a six session program.

* Most research protocols are for 12 or more sessions

Recognition needs also to be given to the fact that many patients enter therapy with one issue, only to have other circumstances require intervention. Consider the patient who is referred for panic attack (presentation to the GP) and through therapy it is discovered that the patient has attachment issues and has experienced many losses in their life. While the panic may be addressed in 6 to 10 sessions, circumstances such as the loss of their job or ending of a relationship during therapy would place them at high risk with ongoing needs including, perhaps, suicidal ideation. Therapy is dynamic and dependant on the patients needs at the time of intervention. Another example case involved a woman with borderline personality disorder who had developed anorexia after gastric banding for obesity. This complex case required significantly more than ten sessions and while her weight has been stable now for several years she is at risk of suicide due to a range of factors including relationship issues, financial issues and family issues. Her treatment has allowed her to stay in employ and continue to make progress, albeit slowly. Recognition of co-morbid conditions is not well understood in the current protocols and would be better served by a psychologist's formulation and treatment planning process.

* Therapy is dynamic and must take into account an individual's changing circumstances

Considering the productivity in keeping these patients in the workforce and in reducing the burden on public hospitals, there is a social justice imperative to develop protocols that allow complex cases to continue to have access and participate in therapy. Inpatient costs exceed many hundreds of dollars daily and needs to be balanced against the variety of outpatient services, of which private services provided by psychologists is one of the few growing components.

* Productivity gains must be taken into consideration when allocating funding

What constitutes a referral has become a bureaucratic nightmare for clients and practitioners. Clients in particular, already a vulnerable group, are faced with a variety of avenues that their referrals can be made under. Take for example the parent of a child who goes to their GP and is referred under the Better Access 2710 item process to an Educational and Developmental psychologist; the parent is aware of another psychologist through whom they can receive a higher rebate and wonders why this is so; the child is also referred to a Paediatrician who diagnoses and refers under their item number; however at the end of several sessions the family is unable to meet the costs of the service under these item numbers and is consequently referred by the GP under the ATAP program where there is a minimal out-of-pocket charge. Under this situation the psychologist has had to manage three different referral processes and inform the parent as to why there are different protocols for each, including different costs to the parent.

* The bureaucratic demands of the 2710 process add costs that must be passed on to the consumer

There is also significant confusion between referrals to Medical Specialists being 12mths from the date of referral and mental health referrals lasting two years with sessions counted in a calendar year. Some patients have had treatment refused by GP's insisting that a patient wait until the anniversary of the original referral before completing a review. Consistency between referral processes will alleviate confusion.

* Confusion exists between referrals based on traditional twelve months and mental health calendar basis.

The current lack of information regarding the interaction between Better Access and Better Outcomes makes it very difficult to comment on a patients' ability to participate in mental health interventions and therapy. Currently, ATAP services are only available to clients on low incomes who are socially disadvantaged, have a health care card, and are either homeless, ATSI, youth or aged, or are drug or alcohol dependent, etc. Without support, working Australians with moderate to severe mental illnesses and complex co-morbidities may have to leave the workforce because they can't afford to continue receiving psychological treatment without Medicare rebates under the proposed 6+4 session model. This will no doubt add a greater financial burden to the already overburdened welfare and public mental health systems. Keeping productivity high mitigates the cost of mental health services.

* There is little clarity in regard to duplication between Better Outcomes and Better Access programs.

(iii) the impact of changes to the Medicare rebates and the two-tiered rebate structure for clinical assessment and preparation of a care plan by GPs,

Clinical assessment is an area poorly understood by the general community. There is some misconceptions that only Clinical Psychologists are capable to undertake case formulation and treatment planning – this is **not** the case. All psychologists are required to be skilled in case formulation and treatment planning as a PBA requirement for registration. Enhanced training is then undertaken by **all endorsed psychologists**, as is a requirement of APAC and PBA. Indeed if we take the case of Educational and Developmental Psychologists, who have a broad lifespan developmental approach to psychopathology in the context of understanding both normal and abnormal development and life long learning, is required by APAC to complete courses in Lifespan Psychopathology as part of Masters level coursework. So significant has been the influence of this lifelong perspective that a lifespan approach to mental health is now being recognized in the changes being considered for the DSM 5, due for publication in 2012 after an extensive revision based on developmental perspectives.

* **Psychopathology** is a component of all APAC approved courses, as is **enhanced** training in psychopathology leading to endorsement.

The PBA has emphatically stated that there are no 'specialist' psychologists as training and practice are not restricted in the same way medical practitioners who specialize in an area of medicine are restricted. A Psychiatrist does not work as an Endocrinologist when they feel like it. The issue is one of terminology. A 'specialist' only works in one specific area of practice. As all psychologists must, to meet registration requirements, undertake sufficient studies in psychopathology, a 'specialist' would have to undertake specific studies and work in one area only, for example, schizophrenia. As this is not the case the PBA has ruled that there are no specialist psychologists.

* Terminology must be consistently understood and applied by all I these discussions.

Another term in confusion is 'Clinic', a term used to describe a centre primarily devoted to the care of outpatients. Any Allied Health Worker in an outpatient facility is working in a clinic and can be considered to be undertaking clinical work. Consequently many doctors and patients refer to non-clinically endorsed psychologists as 'clinical psychologists' purely on the basis of their work in a clinical setting. The Mental Health Workforce Advisory Committee 2008 statement on the future supply of psychologists stated

Much of the data reported on clinical psychologists actually refers to a broader group of psychologists, with data based on self-reported work that is directly with patients or in a clinical area. These psychologists are a broader group than membership of the APS CCP(college of clinical psychologists), as not all those working in a clinical area are members of the APS CCP.

Psychopathology training is undertaken by all psychologists, and enhanced training by all endorsed psychologists, and should not be misunderstood as a purely clinical college specialty. Educational and Developmental Psychologists are central in the provision of mental health services to infants, children, adolescents and their parents, aged care and general developmental issues, in private, public, and corporate practice, and through the education network. In recognition of advanced training in psychopathology across all endorsed areas of psychology, differential payments to Clinical College/PBA Clinically endorsed members is inequitable and may contravene the Fair Trading Act (Qld). This inequitable situation is further inflamed where Medicare does not utilize the same differential in items for Autism, Disability, Pregnancy Support Counselling and Chronic Disease, all of which are clearly aligned with areas of endorsement other than clinical. Psychologists remain distressed that endorsement in other areas is not valued in the same way that clinical college endorsement is through the Medicare two-tiered system. This distress is both professional and financial.

* Differential payments for the same service by similarly qualified people may contravene the Fair Trading Act (Qld)

The introduction of the two-tiered system also does not take into account, nor value, clinical experience. Given that the issue of endorsement was only legislated in 2010, individuals with significant experience have been disadvantaged by onerous, costly, and time consuming processes to have their experience recognized. Many colleagues have reported that experience has not been utilised at all through the application process for Clinical College

* Clinical experience has not been valued in this

membership/endorsement – the pathway to recent endorsement recognition. In essence this has granted the Clinical College power over the number of college members and places them in an industrial position regarding workforce numbers similar to Medical Specialist processes. The application for endorsement, processed through the APS, has focused on university training programs and in no way acknowledges the self-initiated development individuals undertake in professional reading and discussion over what, in many cases, has been decades. Individuals, up to 2010, made career decisions based on legislation at the time. The change of circumstances brought about by the introduction of new legislation did not reflect the reality of these individuals work circumstances.

transition to the PBA and in the two-tiered system introduced by DoHA through Medicare.

Even if these experienced clinicians investigate university places available to meet the new requirements they will find it is almost impossible to secure a post-graduate place, let alone allocate sufficient time and money taking you away from your own practice. Interestingly, two cases have been brought to my attentions where psychologists endeavouring to gain clinical endorsement in Australia, who have worked overseas as clinical psychologists, have had imposed on them an impost in the form of further study and supervision. This contravenes our free trade agreements with their country of origin in terms of mutual recognition and suggests that Australia is endeavouring to surpass standards of qualifications in other countries. Further investigation is warranted into the restriction of clinical endorsement if this is to be a measure associated with Medicare services.

* Suitable provision is needed to 'grandfather' clinicians' into the new legislation.

The Howard Government and DoHA have unwittingly been drawn into what has been a historical debate within the profession. Interestingly, the history of the APS Clinical College has been one of industrial action. A brief overview of the college shows that it was established after Western Australian psychologists' working with Psychiatrists were demanding the Australian Branch of the British Psychological Society (forerunner to the APS) undertake industrial action in regard to remuneration. As the branch was seen as a *learned* society at the time this action was not taken and a Western Australian, by the name of Jeff White, lobbied for the establishment of the Division of Clinical Psychologists within the newly formed Australian Psychological Society in 1969. How prophetic was Jeff White in the use of the term "division'! Other psychologists were well acknowledged in their fields and did not consider this a need. Queensland, unlike Western Australia where political conflict was most evident and the dollar (or pound as it was back then) an imperative, maintained by law until 2010, the referent title of "psychologist" without description, and all having to meet the same standards for registration. While today standards remain equivalent for registration of all psychologists, *endorsement*, once the realm of APS colleges on the basis of further study and practice (many early college members were granted membership in recognition of experience), has become pseudo-specializations within the field of psychology. The APAC accreditation of courses has ensured that ALL Masters degree programs for psychology leading to endorsement by the PBA attend to both normal and abnormal psychology. The APS, until recently, facilitated this APAC process and is aware of this significant overlap.

* The two-tiered system has triggered a debate put to rest in Qld years ago, where psychologists were not permitted to represent themselves as anything other than 'a psychologist' in recognition of the lack of specialisations in psychology.

College members who purport to hold a specialization are indeed in breach of the APS Code of Ethics that states
*This Code defines a psychologist as "Psychologist means **any** Member irrespective of his or her psychologist registration status." (APS Code of Ethics, p.10)*

This Code also states
*c.2.3 Statements made by psychologists in announcing or advertising the availability of psychological services, products, or publications, must not contain: (a) any statement which is false, fraudulent, misleading or deceptive or likely to mislead or deceive; (b) testimonials or endorsements that are solicited in exchange for remuneration or have the potential to exploit clients; **(c) any statement claiming or implying superiority for the psychologist over any or all other psychologists; (d) any statement intended or likely to create false or unjustified expectations of favourable results; (e) any statement intended or likely to appeal to a client's fears, anxieties or emotions concerning the possible results of failure to obtain the offered services; (f) any claim unjustifiably stating or implying that the psychologist uses exclusive or superior apparatus, methods or materials; and** (g) any statement which is vulgar, sensational or otherwise such as would bring, or tend to bring, the psychologist or the profession of psychology into disrepute. (APS Coe of Ethics, p.27)*

* The two-tiered system fosters a breach of the APS Code of Ethics.

All psychologists in private practice deal with a variety of cases and patients have a variety of expectation that the psychologist can be dealt with their issues. Our training therefore reflects this. In most cases it is financially and pragmatically impractical to overly restrict practice to one area of interest. Consequently most psychologists in private practice have a variety of referral sources and see a variety of cases. Just like GP's there is a reliance on the

*Pragmatically

psychologist to then make decisions about their ability to manage a particular case. Indeed the APS Code of Ethics states
B.1.2. *Psychologists only provide psychological services within the boundaries of their professional competence. This includes, but is not restricted to:*
(a) working within the limits of their education, training, supervised experience and appropriate professional experience;

as well as this the Code states
(*d) complying with the law of the jurisdiction in which they provide psychological services;*

Given that the law in Qld stated, until 2010, that all persons wishing to work as a psychologist have sufficient undergraduate qualifications and that any person using the title 'psychologist' could not use a differential title, such as Neuropsychologist, clinicians in private practice, no matter what their enhanced qualifications were, would be acting as a mental health psychology practitioner and seeing a variety of patients for which they would make the assessment of their competency and qualification given that they had met all criteria for registration.

The Code of Ethics also states that
A.2.4 When psychologists in the course of their professional activities are required to review or comment on the qualifications, competencies or work of a colleague in psychology or another profession, they do this in an objective and respectful manner. (APS Code of Ethics, p.12)

It is with great distress that some psychologists have purported to hold themselves as more competent than other endorsed psychologists given the requirements stated above. The efficacy of treatments provided by psychologists has been clearly established by the 2010 review of Medicare.

(iv) 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;
Prevention is better than cure -
Proactive services to target groups (e.g. intellectual impairment; oppositional defiant disorder; conduct disorder) and early intervention is as important, if not more important than, reactive services. The cost benefit economic analysis has proven time and time again that expenditure in early intervention has economic benefits.

Comments on the changes to the mental health item numbers under 2710 are predicated on the access and availability of ATAPS interventions targeted to certain groups. The expansion of Medicare Locals and participation in treatment interventions through this pathway adds a dimension to the planning of mental health services. If these programs assist in continuity of care then they are to be applauded, if they cause a discontinuity then the programs are likely to increase issues rather than meet peoples' mental health needs. As there is little information available to address the ATAPS process it is difficult to comment on the interaction between these two sources of Federal Government support for mental health treatment.

(c) the impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program;
Currently services are only available to clients on low incomes who are socially disadvantaged, have a health care card, and are either homeless, ATSI, youth or aged, or are drug or alcohol dependent. Without continuing support, working Australians with mental health issues, traditionally referred under the Medicare 2710 item, may consequently leave the workforce because of affordability issues and continuity of psychological treatment without Medicare rebates. This will undoubtedly add a greater financial burden to the welfare system or public health service provisions. Keeping productivity high mitigates the cost of mental health services. It is hoped that a smooth transition between Better Outcomes and Better Access will be possible for ALL patients with extenuating needs.

(d) services available for people with severe mental illness and the coordination of those services;
My experience has been that people with severe mental health issues are often best serviced when acute inpatient programs maintain contact and coordination with private and outpatient programs in chronic mental illness. This will be difficult if there are insufficient sessions available to people with severe mental health issues. As previously reported, the therapeutic relationship is an integral part of the treatment process and policies that require patients

psychologists in private practice have been registered to be able to liaise with referral sources and deal with a variety of referrals made to them.

* In making career decisions in Qld psychology until 2010 we were all referred to as psychologists and trained accordingly.

* Prevention is better than cure

* Little information available about the interaction of various programs and continuity of care.

* A smooth transition between Better Outcomes and Better Access is necessary for patients in need.

* Continuity of care is a critical aspect of mental

to move between inpatient and outpatient processes can disrupt continuity of care.

health services.

(e) mental health workforce issues, including:

(i) the two-tiered Medicare rebate system for psychologists is forcing students into Clinical programs as the rebate is so significantly higher that it is untenable to undertake a Masters qualification in the anticipation of being so severely disadvantaged on it's completion. As mentioned previously the training in lifespan psychopathology is a requirement of PBA and APAC approved Masters degree courses and consequently enrolment in anything other than a clinical program is a financial disadvantage.

* The two-tiered model is forcing students into clinical programs.

This is despite the overwhelming support from consumers regarding the efficacy of treatment from all clinicians. The Medicare Review (2010) stated
The key recommendations from consumers on how the Better Access initiative could be improved were to reduce the gap fee for seeing allied health providers and introduce a more equal rebate for all approved allied health professionals. P42

* Consumers want greater equity in rebates.

When a private psychology practice is established there are identifiable costs in running the practice. The fact that such a significant differential in rebates is applied to Clinical when non-clinical Masters qualified and endorsed practitioners will have the same costs for the same cases it is financially disadvantaging to the non-clinical psychologist.

* Financial consideration is necessary to ensure all psychologists have the opportunity to develop evidence based quality private practices on an equitable basis given equitable outcomes.

The advent of eHealth will also complicate the issues faced by private practitioners, forcing more non-clinically endorsed providers out of private practice despite a wealth of experience and qualifications.

The APS has developed Private Practice Management Standards which, when implemented, will facilitate the private practice protocols for psychologists. A number of psychologists continue to practice as if their profession is a 'cottage industry'; that is, they practice in isolation and from their home in order to minimize outgoings. The outcome of this may include a risk that these psychologists lack immediate peer supervision, are more likely to break ethics codes, and are less likely to have access to a variety of supportive resources such as assessment devises. The 2010 Medicare review has shown clearly that clients have had excellent service and outcomes from all psychologists working in private practice. The Review stated
Nearly all interviewees across all stakeholder groups reported that Better Access had been successful in facilitating access to appropriate and evidence-based mental health care and achieving positive outcomes for clients' p23.
The Review further reported
Most GPs and psychiatrists acknowledged that the variation in payment failed to capture the expertise of individual providers. p38

* Policies are in place to ensure that private practices meet quality standards.

(ii) workforce qualifications and training of psychologists,
Despite the fact that the basic qualification for psychologists remains a four year degree with two years of supervised work the focus of training has dramatically shifted as a direct result of inequitable funding arrangements. While Clinical endorsement represents less than 15% of the total psychology registrations the impact on course offering has been striking. Currently in Qld there are a total of 9 Clinical Psychology Masters programs for students to choose from and only one each in the areas of Forensics, Health, Sports, Education and Developmental, and Counselling. This is replicated in all other states illustrating the disproportionate pressures in the field of psychology as a direct consequence of the two-tiered model.

* Universities are promoting clinical programs as the funding is flowing in this direction.

Graduates from the 4 yr programs are finding it impossible to gain employment as they can not be fully registered and employers are unable to provide them with supervision due to the high costs of the supervision process. As a STAP accredited supervisor I am aware of the extensive commitment that supervisees and supervisors must undertake in this pathway to registration. Consequently 4yr graduates are finding themselves forced into Masters programs or leaving the profession simply because they do not have access to appropriate work placements and supervision. The flow on from a situation where new graduates are forced into Masters programs is that university places are not accessible to currently practicing psychologists committed, both financially and

* Graduates of four year degrees are struggling to find employment and

pragmatically, to their practice.

Should a four year trained psychologist in a suitable supervision program be able to access a Medicare rebate commensurate to their training, this would provide suitable employment and avenues for professional development toward full registration. Given that Social Workers and Occupational Therapists have access to Medicare with less training in psychology than an honors psychology graduate there is serious concern about the equity of the current Medicare system. A similar rebate for well supervised honors graduates in psychology would assist in providing pathways for the current graduates who, both the government and individuals themselves, have invested time money and effort into achieving this qualification.

The lack of understanding and resultant competition for university placement opportunities for students is evidenced in, for example, the Federal Government funded supervised placements in alcohol and other drug (AOD) programs. These placements were available to students in courses leading to Clinical; Forensic; Neuropsych and Health endorsement despite the fact that alcohol and drug issues is a core developmental concern and listed as one of the areas of specific interest for Educational and Developmental psychologists on the APS website. Educational and Developmental Psychologists were not considered in this funding.

For already qualified and fully registered psychologists seeking recognition of their expertise, there is a lack of realistic pathways for recognition of professional experience and practice. The advent of PBA has meant that any fully registered psychologist desiring to undertake further studies has limited and expensive avenues to upgrade their endorsements. These fully registered psychologists currently find it extremely difficult to gain entry into programs as there are no additional places in programs leading to endorsement and no recognition of prior competencies through extensive practical experience have been allocated specifically for existing professionals. This was promised during the introduction of the national registration process; however to date, there are no programs directed to this.

(iii) workforce shortages;

The disparity between clinical and non-clinical psychology in the Medicare item 2710 process, and the resulting impact on education and training, is likely to lead to a shortage in psychology services in other areas of practice. Take for example Educational and Developmental Psychologists. Already there are too few educational development psychologist in schools nationally particularly in some states like Queensland and policies such as the two-tiered model are a major disincentive to become an Educational and Developmental Psychologist with six years minimum Masters level training is the absence of adequate remuneration. Already in some States it is difficult to attract an educational and developmental psychologist as they are paid far less than teacher's salary.

There is some evidence that since the inception of the Medicare item numbers some schools have relinquished their psychological support mechanisms and are encouraging parents to take their children to their GP for a mental health referral. This will add further pressure to training choices when a potential graduate looks to see that they could be doing the same work, with the same qualifications, for 50% less rebate. Educational and Developmental Psychologists have had a long and illustrious history in all workplace settings; however there is no doubt that there will be an impact on workforce training and the narrowing of perspectives in the field of psychology should this two-tiered situation be allowed to continue.

(h) the impact of online services for people with a mental illness, with particular regard to those living in rural and remote locations and other hard to reach groups;

There is insufficient evidence to measure the costs / benefits of on-line provision of psychological services. Issues such as appropriateness of program self-selection; follow-up; the role of the therapeutic relationship, and duty of care for suicidal patients need to be considered. Information from services provided by telephone (Kids Help Line; Lifeline) highlight the limitations of alternatives to face to face treatment. In the example of suicidal intent the process must have the ability to triangulate calls and work with police where needed. Unmonitored interventions may place individual at risk where their expectations are not met and not monitored.

Despite this there may be avenues for on-line services to provide psycho-education and information services to the public; however further detailed research is necessary before commitments can be made to developing and implementing such programs.

supervision to allow them to progress to full registration.

* Honors psychology graduates have sufficient skills to access some form of Medicare rebate.

* Even within Masters programs placements opportunities are not readily accessible.

* Programs for fully registered psychologists to have recognition of prior competencies are needed.

* Inequity will seriously narrow the psychological areas of professional interest.

* Services previously offered are then likely to be influenced by rebates.

* Further research is required to address the efficacy of online programs.

(j) any other related matter.

Another concern of the current circumstances regards aspects of the professional relationship between GP's and allied health workers which is reminiscent of the relationship between Pharmacists and Medical Practitioners. It has been brought to my attention that some GP practices are engaging psychologists and demanding 50% of the psychologists' earnings as charges for a room. This links a referral to a payment back to the medical practice. This situation has been described by both the APS and Medicare as unethical as it becomes a financial interest to refer a patient to that particular psychologist, rather than addressing the patient's needs by referring to an appropriate psychologist. It is no longer a professional relationship but a financial relationship. The advent of so called 'Superclinics' is also challenged by the possible financial arrangements that Medicare has already deemed as unethical. Pharmacies were no longer allowed to be owned by Doctors for this very same conflict of interest. Psychologists need to be aware that if they enter into an arrangement such as this they are breaking the APS Code of Ethics which states

C.6.3. Psychologists do not receive any remuneration, or give any remuneration for referring clients to, or accepting referrals from, other professionals for professional services.(APS Code of Ethics, p.30)

* Clarification between professional and financial aspects of the referral process is essential.

Another concern with the current circumstances involves children referred for treatment. Children will be disadvantaged by the change to a 6+4 session model as their access to and participation in therapy is quite different from consenting adults. The issue of rapport building and engagement add a further dimension when a child is brought to therapy by a parent. The developmental level and processes make intervention more complex and holistic. Indeed, work with parents becomes a critical aspect in the treatment of children. The current model used in Medicare does not allow for parents to be seen without children being present; however interventions may require the discussion of a child's circumstances without exposing the child to this discussion. Consequently working with children required greater sensitivity to the context of a family.

* When working with children the family context is significant and should be included in Medicare protocols. Parents should be able to be seen alone and sessions extended under extenuated needs.