

MERRILLY WATSON
PSYCHOLOGIST

29th July 2011

Submission to the Senate Standing Committees on Community Affairs: Inquiry into the Government's funding and administration of mental health services in Australia.

Introduction

I am a psychologist who has been registered for 17 years and who has been in private practice for 16 years. I completed my training in psychology (a 3-year undergraduate degree followed by a Graduate Diploma in Applied Psychology) at the end of 1980. At the time, the University of Adelaide did not offer a masters programme, and so, in the 8 years prior to commencing a supervision programme in order to register as a psychologist, I gained valuable experience as a Youth Worker, obtained a second graduate diploma (in Group Work), completed specialised training in Marital and Family Therapy, and worked for the Marriage Guidance Council of Australia (now Relationships Australia) as a couple therapist and group counsellor (for 10 years). During my supervision programme, I also completed the Australian Society of Hypnosis' Diploma in Clinical Hypnosis, and have subsequently undertaken further in-depth training in Clinical Hypnosis and Strategic Psychotherapy.

Since 2005, I have provided training for the South Australian Society of Hypnosis (SASH), and in the last 2 years have been responsible for co- writing and delivering most of the current course curriculum for the Diploma in Clinical Hypnosis. Not only do I teach the fundamentals of hypnosis to qualified health care professionals (psychologists, medical practitioners, dentists, etc.), but also its application to a wide range of psychological conditions, including depression, anxiety, habit disorders, pain, and trauma. I therefore ensure that my training in regard to the current evidence-based treatments for these conditions is regularly up-dated through attending workshops and undertaking journal searches. I have been an active member on the Executive Committee of SASH (formerly ASH (SA Branch)) for the past 10 years, having served as its chairperson for 5 years.

Over the years, I have been contracted by a number of psychologists to provide supervision sessions. Some of these psychologists have had a Masters of Clinical Psychology.

In this submission I wish to restrict my comments in relation to treatment by psychologists only and to specific areas of the Terms of Reference: (b – ii & iv), and (e – i & ii):

(b) Changes to the Better Access Initiative, including:

(ii) the rationalisation of allied health treatment sessions

(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.

Whilst the majority of my clients require 10 sessions or less per year, like many of my colleagues, I have a significant number of clients with severe mental illnesses/complex psychological problems who will be adversely affected by the proposed reduction in the number of client sessions per calendar year from a maximum of 18 to 10. Most of those in this latter group have extensive histories of abuse and/or neglect that have resulted in long-standing and serious psychological problems that cannot be realistically resolved within 10 sessions. Even with 18 sessions per calendar year, a few of these clients have required counselling for several years before significant and stable changes have been achieved. For such clients, the best we will now be able to do is to space out their 10 sessions evenly across the calendar year (approximately one session every 5 weeks) to ensure that they have 'ongoing' support and are not left at risk for more prolonged periods of time without psychological assistance. Clearly, the ability to produce good therapeutic outcomes will be greatly reduced. These clients will be at greater risk than under the current scheme where they can be seen approximately once every 3 weeks over the course of 12 months.

The research indicates that effective 'brief therapy' involves up to 20 counselling sessions. There are many clients who, under the current scheme, make significant progress with between 10 and 18 sessions. The reduction to a maximum of 10 clearly risks these people being left without psychological assistance just over halfway through their treatments. An analogy to this is the patient who only takes half a course of antibiotics. Unless the full course is taken, there is a risk of the person relapsing, particularly when problems like depression and anxiety are only half treated. Given that the current programme has been proven to be effective, it does not make good sense to now reduce the number of sessions available to those in need.

(e) Mental health workforce issues, including:

(i) the two-tiered Medicare rebate system for psychologists,

(ii) workforce qualifications and training of psychologists

The two-tiered Medicare rebate system for psychologists has created enormous divisions within the profession and has no doubt confused referring medical practitioners and the

general public. Furthermore, the process used to determine the endorsement of clinical psychologists has been flawed, with the APS, in my opinion, having failed to comply with the laws of natural justice. I speak from personal experience, having been one of the many psychologists who applied to the APS for endorsement via the 4+2 pathway.

Briefly, just prior to the commencement of the scheme in 2006, Lyn Littlefield, the director of the APS, met with members in Adelaide to inform us of the new scheme. As the majority of psychologists in private practice did not have a masters in clinical psychology, there was a lot of anger and angst regarding the impact of the impending scheme. However, Ms Littlefield assured those of us who had been practising for many years that we would no doubt meet the specified criteria for obtaining 'eligibility', and that all we would need to do was record all the professional development we had done over the years, and make sure that we had undertaken sufficient 'supervision', preferably under someone who was already a member of the clinical college.

Once the programme commenced, my primary concern was to assist my clients by enabling them to receive the higher level of rebate for my services. I also have a social justice policy, and so have chosen to bulk bill a few clients who would otherwise not be able to access psychological services. I hoped that by gaining endorsement as a 'clinical psychologist, I would be able to afford to bulk bill a greater number of clients in need. I reviewed the specified criteria and determined that my training in 2 specific areas (namely 'psychological assessment' and 'psychopathology') was not up-to-date. Hence, I began the long process of updating these areas. I enrolled as a non-award student in the 2 relevant units of the psychology clinical masters course at UniSA, completing the first in 2008 and the second in 2009. Each consisted of about 50 hours of attendance in addition to many hours of work, reading and completing the required assignments. The cost in terms of course fees and lost income was considerable. In terms of new learning, there was little that I had not already learned over many years of experience and pursuing a wide range of professional development through various courses, workshops and peer supervision. However, I believed that the investment would be worth while. In one of the units, I met another psychologist who had already submitted her application to the APS and had been given a 'bridging plan' which included the exact 2 units I was undertaking. I felt reassured that I was on the right track.

Although I had already been meeting regularly with a peer support group for several years (which included one psychologist who had recently qualified for membership of the APS Clinical College), I organised additional meetings with another colleague who was also a member of the Clinical College.

Approximately 3 years after the introduction of the new Medicare scheme, I submitted my application to the APS at a cost of \$500. I was devastated when I finally received a letter of rejection about 4 months later. At the very least, I had expected to be given a bridging plan, being quite prepared to undertake more study or perhaps a placement, if this were deemed necessary. I reviewed the information I had lodged, and determined that the problem must be that I had not submitted sufficient information (the boxes provided on the forms were very small, and so I had only provided minimal details). (The 1.25-page rejection letter gave no specific feedback regarding why my application had been rejected.) Given the time, energy and money I had already invested in my endeavour to obtain clinical status, I decided to appeal the decision.

My appeal was also knocked back. Given the expense of lodging the appeal (\$1000), I had expected to be provided with detailed feedback so that I would have an understanding of where I had met the criteria and where I had failed to do so. Instead, I received another 1.25-page letter (copy below). I believe that by failing to properly justify their decision, the APS has failed to meet the laws of natural justice in this matter. I have been left to wonder in what areas I failed to meet the criteria and what more I would have needed to do!

I certainly do not have the time to undertake the full clinical masters programme (furthermore, I understand that there are very few places available). I am too busy further developing the hypnosis course, co-directing a national congress for the Australian Society of Hypnosis, developing a research project with a group of surgeons, and running my private practice.

I am one of many 'generalist psychologists' who have been disadvantaged and discriminated against under the two-tiered Medicare rebate system. Some of my colleagues have actually completed masters programmes in psychology, but as they were not specifically 'clinical' masters, they too have had their applications rejected.

Given that there has been shown to be no qualitative difference in the therapeutic outcomes obtained by 'generalist' and 'clinical' psychologists, it is hard to argue why the latter group should be advantaged by the higher rebate. It would be interesting to compare the results if the 'clinical' group were to include those of us who have years of *clinical* expertise, knowledge and experience behind us, but who have been excluded by a process that has been anything but open and fair. My view is that either the two-tiered system be abolished and all psychologists be put on an equal playing field, or that psychologists in my position be 'grand-parented' in as 'clinical psychologists'. However, the reality is that 2 years of a specific course of study does *not* produce a superior psychologist. It is the *application* of knowledge and skills, rather than the *acquisition* of these, which ultimately determines whether one is an effective

practitioner or not. And, as in my case, there are many more ways to acquire the requisite knowledge and skills other than undertaking a clinical masters course.

Merrilly ~~Watson~~

Ph:

APPENDIX: APS letter of rejection in response to my appeal



Ms Merrilly Watson MAPS

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Monday 6 April 2010

Dear Merrilly,

Appeal of decision of the Medicare Assessment Team

Your request for review of the decision of the Medicare Assessment Team dated 4 December 2009 has now been considered by the Medicare Assessment Appeals Committee.

The Appeals Committee considered the information before it, as follows:

- Your full application form and all attachments;
- The further information received from you by the Medicare Assessment Team;
- The letter of determination of the Medicare Assessments Team dated 9 September 2009;
- Your letter of request for review/ or appeal; and
- Any additional information received from you after the date of your request for appeal.

The determination of the Medicare Assessment Appeals Committee is that the following decision of the Medicare Assessment Team be upheld:

The Applicant is assessed as not providing evidence that sufficiently demonstrates equivalence to the standard route to membership of the APS College of Clinical Psychologists. The Applicant has been assessed as providing evidence of knowledge and skills acquisition and experience which is not sufficiently strong to support the development of an Individual Bridging Plan (IBP). The Applicant is therefore unsuccessful in their application. Any further assessment will require submission of a further application to the APS Medicare Assessment Team.

This decision affirms the decision of the Medicare Assessment Team.

We are aware that the general recommendation made by the APS Medicare Assessment Team in order to meet criteria for membership of the Clinical College does not always fit with an applicant's current work commitments or life stage. However, provision of this information is considered important to assist applicants in understanding what is required if they are to pursue eligibility for membership of the Clinical College.

Yours sincerely.

Jillian Bull, PsyD (Clin), MAPS
Coordinator – APS Medicare Assessment Team
Australian Psychological Society