



PSYCHOLOGY PRIVATE AUSTRALIA Inc.

THE FEDERATION OF ORGANISATIONS OF PRIVATELY PRACTISING PSYCHOLOGISTS OF AUSTRALIA

CONSTITUENT BODIES

Association of Private Practising Psychologists (NT)
Association of Private Practising Psychologists (QLD)
Australian College of Private Consulting Psychologists (NSW)
Psychology Private Tasmania

Psychologists in Clinical Private Practice (A.C.T.) Inc.
Australian College of Psychologists in Clinical Private Practice (VIC)
Institute of Private Practising Psychologists (SA)

SENATE COMMUNITY AFFAIRS COMMITTEES

INQUIRY INTO COMMONWEALTH FUNDING AND ADMINISTRATION OF MENTAL HEALTH SERVICES

SUBMISSION FROM PSYCHOLOGY PRIVATE AUSTRALIA INC. (PPAI)

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SUMMARY OF RECOMMENDATIONS

Item (b)(i)

1. Do not change existing GP arrangements; improve auditing by Government to ensure that a GP gives value for money when receiving payment for preparation of a Mental Health Care Plan.
2. Create a Medicare bulk-bill Item for use by GPs who refer, on a provisional diagnosis, a patient to a psychologist to develop a plan with a patient and forward the plan to the referring GP for information and consideration. In this situation, the patient may initially have 7 consults.
3. Abandon use of the program to turn GPs into pseudo-psychologists in 20 hours of training.

Item (b)(ii)

4. Do not reduce in number the existing possible 18-session Mental Health Care Plan consults.
5. Use the expansion of Mental Health Services to provide additional funds for persons with personality disorders beyond 18 under the one Plan.

Item (b)(iii)

6. Abandon the two-tier psychologist arrangement in favour of a single undifferentiated psychologist referral cohort utilising one only rebate amount except that if a patient is bulk-billed by a treating psychologist, payment to a psychologist will be greater than the rebate by \$8.

Item (b)(iiib)

7. Ensure no reduction in time allowed or in amount of Medicare payment to a GP for preparation of a Mental Health Care Plan.

Item (b)(iv)

Recommendation No. 4 is relevant.

Item (c)

Recommendation No. 5 is relevant.

Item (d)

8. The Government should raise the rebate amount substantially for a consult with a psychiatrist and to encourage psychiatrists to bulk-bill financially needy patients, increase the amount of the Medicare payment to a psychiatrist for a bulk-billed consult.

Item (e)(i)

Recommendation No. 6 is relevant.

Item (e)(ii)

Item (e)(iii)

9. Direct the Australian Psychology Board to recognize readily for the endorsement system, length of continuous time in private practice and the primary psychological work field combined as the indicator of competence, and not the possession of a particular higher degree for a psychologist in private practice.
10. Have the appropriate authority modify/expand the Provider Number system to allow easy recognition of 'private practice competence'.

Item (f)

Recommendations 4 and 5 are relevant here.

Item (g)

11. Ensure that Senior Public Servants and Ministers responsible for Mental Health Services, consult effectively with 'hands-on' treating psychologists and heed their advice.

Item (h)

12. Provide an On-line counseling/treatment service which is readily workable and controllable for remote location persons with Mental Health needs.

Appendix

Recommendations 9 and 10 are relevant to paragraphs 6 and 7

Introductory Statement

Mental Health Services are delivered by two arms – (i) practitioners employed by Government or Government-backed organisations, (ii) practitioners in private practice

Practitioners are, in the main, from the following professions: psychiatrists, psychologists, general medical practitioners, mental health nurses; and to a much lesser extent, social workers, occupational therapists.

This submission is made from the standpoint and long experience of psychologists in private practice.

The submission will traverse the whole gambit of the Senate's statement of the terms of reference of the Inquiry. It gives, as might be expected, greater emphasis on those 'terms' which bear particularly on psychologists in private practice and which mark them as different from psychologists from the other arm of practice. **To comprehend fully the impact of some of the terms of reference on our profession as it is today, but only to facilitate flow in this submission, several important historical matters have been removed from the main body of the submission and are addressed in the Appendix.**

Competence in the delivery of service is an imperative for successfully remaining in private practice. (i) High quality personal capacity for interpersonal dealings, for diagnostic work, and for appropriate selection of intervention methods and techniques and their sensitive application are requirements for establishing a successful private practice. (ii) Continued professional development is an imperative for maintenance of competence. **Individual differences will exist between practitioners; these over time will sift out those who remain in private practice from those who do not continue.**

(a) The Government's 2011-2012 Mental Health Budget Changes

It is surely a strange contradiction that the Government features an expansion of Mental Health Services in one area of mental health treatment and a severe contraction in another which from the viewpoint of experienced practitioners stands in need itself of greater expansion.

(b) Changes to The Better Access Initiative

(i) The rationalisation of General Practitioner mental health services appears to have been developed in an irrational manner. It is assumed that GPs will be relatively unrestricted, as before, in their autonomy in prescribing psychotropic medications. Reduction of the time spent by a GP in seeking the cause of a mental health disorder (MHD) and as a consequence, the bulk-billed amount paid by Medicare for this service is what the Government intends by 'rationalisation'. It would appear then, that those GPs who do painstaking work in developing a Mental Health Care Program will be penalised for 'the sins' of those who do not. Some other way of discriminating against 'offenders' might well be found by Medicare auditors. Psychologists who receive referrals must in any case themselves obtain a case history. This psychologists must do in order to develop a working hypothesis for beginning treatment – taking note always of the information that is supplied by the referring GP.

Should a GP choose not to develop a plan herself/himself, an item other than 2710 and for a lesser amount, should be created, for the GP to inform the psychologist that the patient is referred on a provisional diagnosis only, and ask the psychologist to prepare with the patient a Mental Health Care Plan at the first consultation and pass it to that GP for consideration. In such a case, the initial six consultations could be increased to seven.

The plan to turn as many GP's as possible into 'pseudo-psychologists' by way of 20 hours of training should be abandoned. It can have the effect only of reducing the number of patients to be treated. It is as ludicrous as it would be to give psychologists 20 hours training in 'surface' surgery and certify them to carry out surgical procedures to remove sebaceous cysts and such-like requiring an incision not exceeding 20 mms in length by 2 mms in depth.

- (ii) The **rationalisation of allied health treatment sessions** in the terms announced by the Government must result in a failure to meet the treatment needs of a significant number of persons in need of a mental health service – persons with chronic mental health conditions. Examples are persons with personality disorders, some of whom for ‘correction’ of the disorder have required more than 100 consecutive sessions. If suicide or lesser forms of self-harm is an ascertained risk for the person, more than one session in any one week may be imperative.
- (iii) **The impact of changes to the Medicare rebates and the two-tiered structure** is not assessed in this submission as it is not clear what if any changes the Government is proposing. However, there are **changes that should be made to both:**
- first*, it is imperative that **the two-tier structure of treatment and of psychologists be abandoned** in order to eliminate a fiction from an otherwise fine initiative;
- second*, and this flows logically from the first, **one single amount of rebate**, say an amount of \$102 – approximately the mid-point between the two existing rebate rates for psychologists – be established. **For bulk-billed patients, there should be a small additional component**, say \$8 paid by Medicare to the bulk-billing psychologist. This would encourage practitioners to bulk-bill needy patients.
- The structure’s fictional element is expressed in the distinguishing names assigned at the outset of the Better Access Initiative to the two tiers: ‘*clinical*’ for one tier and ‘*focussed*’ for the other. In treating a patient, every psychologist enters into a **clinical** relationship with a patient (i.e. if we adopt the relatively recent meaning that psychology has given to ‘*clinical*’, mental-disorder-treating-by-talking; as against the original meaning of ‘*clinical*’, ‘of, at the sick-bed, OED). More, every psychologist must **focus** on his patient and on his work with that patient; but ‘focussed in the ‘Better Access Initiative’ has been invested with the special meaning ‘limited’! No treating psychologist could avoid being guilty of unethical practice or fulfill her/his obligation of duty of care for a patient if this limitation to the treatment needed were accepted. Never since the introduction of the Initiative have experienced ‘focussed’ psychologists accepted this limitation in working with a patient.
- No study has revealed any differences in referred ‘clientele’, in ‘operating procedures’ or in outcomes between the two artificially separated groupings of psychologists. **Within each** of the groupings, of course, as in any occupation or profession, there will be individual differences in competence between members, but with the same range of competence in each grouping.
- (iii) **The Preparation of a Care Plan by a GP** has been considered in some of its aspects already. One further aspect should be noted and considered. Experienced psychologists in clinical practice invariably have sought underlying causes of psychopathological conditions and symptoms in patients they treat. GPs appear more often than not to treat symptoms. The act of diligently preparing a treatment plan involving a psychologist, appears with some GPs to have moved them in the direction of an aetiological consideration of a patient’s symptoms. This surely is one very good result of having a GP herself/himself (and not using an assistant to do the job) develop Mental Health Care Plans. **GPs should be encouraged to do this and not discouraged by reducing their time and the amount of the Medicare payment.**
- (iv) **The Impact of Changes to the Number of Services for Patients with a Mild or Moderate Mental Illness** will be to vitiate the Initiative. Its introduction was aimed at providing an effective mental health service for all persons with a chronic mental health condition who could not afford to pay for its remediation. ‘*Mild*’, ‘*moderate*’, ‘*severe*’, really are very loose terms, but they will suffice for this topic’s consideration. *Mild* conditions may experience remission in six or ten treatment sessions, and even these may have an underlying cause that has to be treated in order to ameliorate the distress of its symptoms. *Moderate* symptoms, that is those that fall short of needing admission to a hospital or referral to a psychiatrist, usually require more than ten treatment sessions to achieve a satisfactory level of remission of symptoms and often more are needed to ensure satisfactory remediation of an underlying cause of the symptoms.

To ensure no reduction in level of service to needy patients, there should be no reduction in the number of consults available to a patient; indeed experience suggests that there should be an increase in the number to accommodate very special cases.

- (c) **The Impact and Adequacy of Services Provided through the ATAPS Program**, over the years, under the Better Outcomes Program has, by many psychologists been considered to be of limited use to persons experiencing psychological distress. In some jurisdictions it is complex in its applications, cumbersome in its paperwork demands, insufficient in its number of consultations provision, and short in amount of overall funds required. From fairly recent consultations that have been conducted throughout Australia in respect of revision and revitalisation of the ATAPS program, many psychologists in private clinical practice would prefer not to be implicated in a scheme which could mean that, in the midstream of treatment, a patient may have to be transferred from Better Access to a Scheme which from their past experience would prove only less facilitative of effective patient treatment. **Some little ‘tweaking’ at its upper edge of the Better Access Scheme is seen as ensuring a better outcome for a patient with a complex psychological disorder e.g. borderline personality disorder or paranoid personality disorder.**
- (d) **Services Available and Their Coordination for People with Severe Mental Illness**
The severely mentally ill need a service of planned medication and perhaps ECT that psychiatrists provide to such persons either as outpatients or when hospitalised. It is known that many psychiatrists in private practice do not bulk bill. Most severely mentally ill persons cannot afford to pay the large ‘gap’. **The Government should recognize the hardship that this imposes on an extremely needy group in the mental health field and significantly raise the Medicare rebate for a consultation with a psychiatrist or the amount that ‘a bulk-bill’ will return to a psychiatrist.**
- (e) **Mental Health Workforce Issues**
- (i) **The two-tiered Medicare Rebate System for Psychologists** has been considered in the context of **Item (b)(iia)** above. In the interests of the persons needing treatment under the Better Access Initiative and also in the interests of non-discrimination amongst equally competent psychologists in clinical private practice, the two-tiered rebate system **should be abolished** (the sooner the better) **and replaced by a single ‘treating psychologist’ system.**
- (ii) **Psychologist Workforce Qualifications and Training** for years have been set by State and Territory Psychologists Registration Boards. Registration legislation has required a basic four-year qualification for all applicants plus, as equivalents, **either** a psychological work/professionally supervised period of two years’ experience **or** a two-year further ‘applied’ academic course followed by a psychological work/professionally supervised period of 1 year’s experience. Given favourable conditions –the usual – the two years of hands-on experience can be expected to produce in the 7th year from commencement of training a more competent practitioner than a psychologist entering the 7th year from 6 years of academic training. **No study has shown that in the longer term one or other training pathway results in superior practitioner competence.**
In the area of private practice, it is the market place and word of mouth that will sort out practitioners in respect of competence. Thus, the test for a private practitioner is not ‘the pathway to registration’ but ‘performance in the workplace’.
The Provider Number System, we believe, could be readily modified to signify a sufficiency of quality experience and competence in psychological distress/mental disorder treatment, with no reference whatsoever to ‘registration pathway’ being relevant.
- (iii) **Workforce shortages** are likely to become greater as a result of the agreement of the Government to permit the Australian Psychology Board to administer its ‘Endorsement System’ in the discriminatory fashion that it has chosen to adopt. In all jurisdictions except Western Australia,

psychologists in clinical private or non-private capacity were, until 1 July 2011, recognised by the public and by other professionals by the nature of the psychological work they were doing. The Australian Psychology Board has chosen to discriminate against all psychologists who achieved registration by way of the 4-year academic pathway. **The Government should use its powers to instruct the Board to adopt a realistic and competence-worthy process in awarding endorsement as a 'clinical' psychologist, recognising that it is not the possession of a higher degree that confers competence on a treating psychologist practitioner.**

(f) The Adequacy of Mental Health Funding and Services for Disadvantaged Groups

On the issue of each of the three specific groups mentioned in this Item, we have nothing to offer. However, as persons in each of these categories are treated under the Better Access Initiative, we must emphasise the fact that **the proposed reduction in funding flowing to the Better Access Program will be certain to disadvantage persons in each of these categories. The proposal to reduce Better Access funding must be withdrawn and possibly reversed.**

(g) A National Mental Health Commission unless given power of such organizations as the Australian Psychology Board would merely add another 'top' group to a relatively uninformed tier of governance in the field of Mental Health Services delivery and reduce the funds available to service the needy. **Senior Public Servants and Ministers at present responsible for the administration of the range of subsidised psychological services should be directed to listen to the voice and heed the advice of a large 'ignored' body of hands-on practitioners in the field of treatment of the needy.**

(h) Provision of an On-line Mental Health Service to Distressed/Psychologically Disabled Persons in a Remote Location is very much needed. Some psychologists are at present providing free of charge, a telephone treatment and counseling service to remote individuals who, in desperation phone in asking for help. **Difficult and all as it will be to set up such a service, our organisation is prepared to work with a Government party including doctors, to the end that a workable and controllable service will emerge.**

(j) Other Related Matters

- (i) For many years before it was possible for psychologist-treated mentally distressed persons to access Medicare benefits, many psychologist-entrepreneurs were successfully offering a 'patient treatment' service. Rebates are not for the financial benefit of the practitioner, but for the benefit of the patient who cannot afford the practitioner's consultation fee. However, registered but inexperienced psychologists from the 6-year academic pathway have, in significant numbers entered private practice, lured by the prospect of a ready-made Government-funded clientele and the differentiating label '*clinical*'.
- (ii) In two ways the Australian Psychological Society recognises that there is no difference in competence between its treating psychologists from either registration pathway:
the first, it promulgates the same suggested consultation fee for all treating practitioners;
the second, it does not differentiate on grounds of registration pathway, one psychologist from another in its listing of treatment-service-offering practitioners.
- (iii) Executive members of Psychology Private Australia Inc. would welcome the opportunity to meet with members of the Senate to discuss issues traversed above and in the Appendix.

Historical Matters

1. From the early 1980s to the early 2000s, interested individual members of the Australian Psychological Society (APS) as well as member Associations of Psychology Private Australia Inc (PPAI), from time to time made submissions to the Commonwealth Government of the day to have Medicare benefits made available to people with a treatment-needing level of psychological distress. Government financial support by way of a limited scheme (Better Outcomes in Mental Health) was introduced in 2003/2004. Legally registered psychologists in clinical private practice, 'registered' also as such with a State GPNetwork who administered the Scheme, supplied the treatment service. Referrals came from a GP. Treating psychologists were quite undifferentiated in terms of 'pathway to legal registration'. Experience in clinical treatment, competence in diagnosis and success in therapy were the criteria for acceptability to receive referrals under the Scheme.
2. In April 2006 the then Prime Minister announced that a much more generous treatment initiative (Better Access to Psychiatrists and Psychologists) would be commenced on 1st November 2006. PPAI offered its services to the Government to assist with the implementation of the initiative. Senior Public Servants engaged in discussions with PPAI, and a delegation from PPAI was received by the then Parliamentary Secretary for Mental Health. PPAI's representations were of no avail and a two-tier division of psychologists and of types of mental disorder and distress was set up – a fundamental departure from the still-existing BOIMH scheme. This relegated the majority of very experienced psychologists already in private clinical practice, to a very limited set of permitted intervention techniques working with patients with limited permitted distress conditions. The division was made on the ground of possessing or not a relatively recently-introduced Clinical Masters degree.
3. Whoever devised a system where treating psychologists could be divided into two tiers (one to assess and provide therapy, the other merely to provide focussed psychology therapy) was quite devoid of understanding of clinical psychology practice as it was in the real world, and still is. All psychologists in private practice then were and now still are fully aware that it is unethical, impractical and impossible to adequately treat without assessment, and in particular without first taking a comprehensive clinical history and attaining an understanding of what the patient's problem is, as well as the various factors contributing to the problem.
4. There is no evidence to show that current Masters graduates in Australia are better trained or more competent in clinical practice than psychologists who were trained before there were any Clinical Masters degrees offered in Australian Universities. Neither is there any evidence to show that those practitioners who, in recent years have chosen to work in the clinical field, are notable for competence defects attributable to non-possession of a Clinical Masters degree.
5. The Australian Psychology Board (APB), despite there being no demonstrated reason for so doing, has chosen to perpetuate the fiction of superiority derived from completion of a particular academic course. The 'endorsement' system adopted by the Board has had the effect of relatively few psychologist being 'endorsed' and able to use a descriptor title – factually unimportant in practice, but having an appearance that beguiles the public and referring professionals. (The situation is most egregious when it is noted that psychologists not possessing an 'applied field' Masters degree have been automatically endorsed on the ground of membership of a College of the APS.) Non-endorsed psychologists (the great majority) in all

jurisdictions other than Western Australia have since 1st July 2010 suffered down-grading from the public-confidence perception that previously they had enjoyed. **Thus the Board's system of discriminatory endorsement adversely affects the profession as a whole, the promotional prospects of experienced practitioners working in an organisation, and of greatest importance to PPAI, the public's and the GP's referral choice of a treating psychologist. Government should move to force the Board to endorse all psychologists who, before 1st July 2010 were recognised in their jurisdictions as registered psychologists who worked primarily in a particular 'endorsable' field of psychological practice – not necessarily in a private capacity.**

6. Historically, except in Victoria, long before Registration Boards came into existence under legislation, Universities worked in close association with the APS to have psychology courses accredited for the purpose of obtaining professional membership of the Society. People then paid fees, studied and achieved the status of practising psychologist.

As Registration Boards were legislated into existence in the States and Territories, the 'litmus test' for registration was the holding of current full membership or of an academic qualification plus experience that would suffice to gain Society membership. **It is virtually fraudulent to imply, and even to state, that these past years' accredited courses would not now be – are not now – sufficient to justify 'particular field' endorsement. Experience in practice coupled with its simultaneous continuing professional development is virtually totally ignored by the Board – the Board should be directed by Government to revise its endorsement system to give full consideration to this more important contribution to practising competence.**

7. About 1988 the APS changed its course accreditation rules to eliminate from the basic four-year course all 'hands-on' psychological practice skills units including assessment and diagnosis. These now are covered in the 'particular field' Master degree courses and skills are acquired in that degree of exactly the same nature (hopefully) as they were acquired in undergraduate and post-graduate applied diploma courses prior to 1988 to 1991. The non-Masters pathway applicants for registration acquire these skills in their two years on the job and under a competent, hands-on experienced professional supervisor.

8. Finally, this organization, PPAI was established in 1988 to bring into a Federation the organisations of psychologists in private practice in each of the jurisdictions. Each of these, for the most part independently of the others, had been established by groups of APS members who found that the APS had little or no interest in issues, State- and Commonwealth-wise that were pressing matters for psychologists in private practice. Intense interest sprang to life, however, from employed psychologists and from University staff as 'moonlighters', when a major scheme to give patient access to Medicare rebates was announced. Many of these 2006/2007 newcomers to private practice appeared primarily to be interested in increasing their incomes and not in improving/extending/enhancing the service provided to persons seeking solutions to distressing psychological aspects of life.