SUBMSSION TO RETAIN THE HIGHER REBATE FOR SPECIALIST CLINICAL PSYCHOLOGY SERVICES

Expertise

As a UK trained clinical psychologist, the BPS recognised some 2 decades ago the value of specialism and expertise provided by clinical psychologists. The report the BPS commissioned clearly suggested that almost all health care professionals use level 1 and 2 skills and some have well developed specialist training in level 2 activities. The report argued that clinical psychologists are the only professionals who operated at all three levels [Level 3 - Activities which require specialist psychological intervention, in circumstances where there are deep-rooted underlying influences, or which call for the discretionary capacity to draw on a multiple theoretical base, to devise an individually tailored strategy for a complex presenting problem. Flexibility to adapt and combine approaches is the key to competence at this level which comes from a broad, thorough and sophisticated understanding of the various psychological theories].and (quote) "it is the skills required for level 3 activities, entailing flexible and generic knowledge and application of psychology, which distinguishes **clinical** psychologists..."

Consequently, Clinical psychologists provide a breadth of treatment interventions for a wide range of psychiatric, psychological and mental health problems.

Clinical Psychologists have extensive training in the theoretical and conceptual understanding of mental health problems, the correct diagnosis and clinical evaluation of these problems and on effective management and treatment.

Clinical Psychologists are trained as scientist-practitioners. This added emphasis on the scientific model in University training enables the profession of Clinical Psychology to bring research and empiricism to service delivery in mental health and thus increase accountability. Evidence (Stoltenberg & Pace 2007) indicates that without adequate scientific training, clinicians will have difficulty applying empirical knowledge to clinical work.

Clinical Psychologists because of their specialist training play a preventative role in minimising disabling symptoms or preventing relapse in individuals experiencing severe and enduring mental health disorders such as those in the psychotic spectrum, bipolar affective disorder, major depression, psychosomatic disorders and substance abuse and the more intractable personality disorders.

Clinical Psychologists design and implement programmes for relapse prevention, reducing the pressures that lead to frequent re-admissions. Without access to clinical psychology services the most vulnerable mental health clients are more likely to relapse, placing greater strain on the public health system/ hospital beds and community teams which are already struggling under the current burden of providing care.

As Specialists, Clinical psychologists are highly experienced in clinical assessment, psychometric testing, formulation, intervention and evaluation. The scientific-practitioner model that clinical psychologists are specifically trained in allows practitioners to more comprehensively formulate and plan treatment interventions and evaluate service provision.

The specialist training in the treatment of complex cases often seen in psychiatric hospitals and clinics, and by psychiatrists, means that clinical psychologists have advanced levels of clinical skill in diagnostic clinical evaluation, neuropsychological and psycho-diagnostic assessment, and comprehensive functional analyses. Commensurate to the length of training, work with complex cases means more expertise in the differentiation of factors precipitating and maintaining the disorder. The level of theoretical training in clinical psychology means that Clinical Psychologists have greater competency in the application of this knowledge to practice with mental health clients.

Assessment

Clinical Psychologist's expertise in mental health means we are routinely consulted by General Practitioners and Psychiatrists, to provide additional diagnostic information and assist with differential diagnoses of complex cases. The process of diagnosis, assessment and formulation is essential for the effective management of complex mental health disorders. Clinical psychologists are trained and skilled in neurocognitive assessment and psychometric assessment including assessment of personality, which is integral to diagnosis and treatment. As a result of the solid psycho-diagnostic training of Clinical Psychologists, they make a major contribution to the use of diagnostic instruments that evaluate mental health status.

The scientific-practitioner model means that Clinical Psychologists, as a result of their training, have the specialist expertise to evaluate and determine whether new assessment tools may be correctly and ethically applied to mental health problems and to expertly undertake such testing.

Registered psychology training

Over the years as a qualified Doctor of Clinical Psychology and accredited supervisor, I have supervised students undertaking clinical training and Masters of forensic psychology, peers who are clinically qualified, as well as 4+2 psychology interns seeking registration. My clinical opinion is that the latter are often employed in areas where they receive little or no actual access to clinical treatment of clients. On the basis of this experience I have no doubt that in terms of confidence in who I would refer a member of the public to, it would be a clinical psychologist.

Alternative routes to becoming registered are largely based on apprenticeship rather than the University based scientist-practitioner model of clinical training. Competencies required for registration as a psychologist are generic and do not recognise specialities. In order to qualify as a Registered Psychologist, the NSW Psychologists Registration Board deemed "an Intern's eligibility for full registration will be determined by assessment of his/her competence in **core** areas of

psychology skills and knowledge", not specialised areas of psychology as is the domain of clinical psychology. Of the five Key standards to be achieved only one relates to Assessment and Measurement. Of this the requirement is to "administer, score and interpret at least **one** test (intelligence, personality, functional, suicide risk, and other) in each of these categories. Only two need to be supervised. So a Registered psychologist can undertake diagnostic and assessment with a minimum of only having administered the relevant test **once.** The area of assessment requires substantial familiarity with psychometric measures which clinical training and on going service practice provides. This allows clinical psychologist repeated exposure to mental health disorders and complex cases. The Registration Board makes no specific requirement relating to the scientific practitioner model in the treatment of a variety of mental health disorders nor requirements related to specific treatment of mental health disorders. The Registration Board, to quote, requires interns to only "adopt and demonstrate evidence based interventions **when available**", "demonstrate **competence** in **basic counselling** skills".

Many 4+2 /5+1 intern psychologists have extremely limited (as in the requirement of 20 hours per week each year), if any, access to clinical mental health settings. The Board's only requirement is that the "placement must provide an Intern with the opportunity to experience systematic exposure to the practice of psychology" not specifically within mental health settings as is the requirement for Clinical psychology.

Many 4+2/ 5+1 trained generalist psychologists seek supervision from Clinical psychologists because the latter are more expert in their training and experience. What would the incentive be for clinical psychologists to now further the professional development of these peers who propose we are all equivalent?

To classify all providers of psychological services as being equal is tantamount to saying all GPs can provide specialist medical interventions such as psychiatry or that all Assistant Nurses can provide the same service as a Registered nurse – an analogy that I'm sure the Medical Association of Australia and the Nursing Association would take serious exception with.

In terms of expertise, clients pay for what they get, which is why specialist treatment by clinical psychologists in the area of mental health needs to be accordingly recognised and financially compensated.

International equivalence.

The proposed scheme seriously questions why the crème of psychology graduates would even bother spending thousands of dollars pursuing a higher specialised degree. In order to keep updated with overseas requirements several Universities have moved to Doctoral Programs. What would be the impact on Universities of a decline in enrolments?

Most countries require at least a Master's level qualification to practice independently as a psychologist offering clinical services "*even at the most basic level*.". The 'dumbing down' of (clinical) psychology for the masses means that Australia will not remain competitive on the international stage as there will be no equivalence across

countries, and the professional standing of Australian trained psychologists will be severely compromised. Overseas trained clinical psychologists (who are uniformly at the doctoral level in the UK & USA and have been for decades) would have no incentive to work in Australia as they would not be recompensed for their level of experience and training.

Furthermore, if the current proposal were to go ahead it is likely to lead to a 'brain drain' of our most qualified practitioners to those parts of the world where they would be recognised. Australia already professionally and internationally struggles to compete on the international stage in terms of recruitment and retention of highly qualified professionals. With any exodus of Senior Clinical Psychologists and Clinical Psychologists, who are more experienced practitioners, who would the lesser qualified generalist psychologists then get supervision from? The danger of the current proposal is that each year the level of expertise in the profession gradually gets watered down more and more.

Any psychologists trained in Australia will struggle to establish equivalence and to be able to work overseas. For many, overseas employment is a valuable asset that clinicians can bring back to Australia. Now what would the incentive be?

Clinical Psychology: Legal Accountability

The 'watering down' of the profession of psychology means that those individuals who have the most serious mental health and psychological disorders are most vulnerable to increased risk of relapse and danger to themselves and others without specialist treatment.

Those practicing Psychology who are not adequately trained in mental health, are legally vulnerable to civil action regarding claims of professional incompetence by disgruntled patients. I wonder how many of these generalist psychologists might then pursue legal action against the Government for endorsing them as adequate practitioners?

Professional recognition

As a result of their training, Clinical Psychologists have a thorough understanding of varied and complex psychological theories and have the ability to formulate and treat a wide variety of disorders, including complex and co-morbid disorders, generating interventions based on a solid theoretical knowledge base. This very high level of specialist competence of Clinical Psychologists is acknowledged by all private insurance companies who recognise Clinical Psychologists as providers of mental health services.

I question if all psychologists are regarded as the same, why have Universities bothered to have Masters and Doctorate Clinical training programs accredited by the Australian Psychological Society (APS) and why for years has the APS itself had a Clinical College amongst other specialist Colleges?

Clinical psychologists are legally required to be registered with the PBA and as part of the requirements of the PBA, clinical psychologists must undertake at least 16

hours of professional development relevant to that specialism. If the professional registration body deems that there is a difference in specialisms above 'generalist' professional development requirements, why is there as disparity with Government and provision of Medicare services and the Board's own guidelines?

In Australia because of the way clinical training programs are set up, clinically trained psychologists have invested considerable amounts of money in obtaining this higher degree plus supervision to meet the APS and PBA requirements for entry into the Clinical College and therefore, to provide the higher rebate to those clients who most need specialist mental health services. What has this all been for?

Service Access.
As a clinical psychologist I see many clients who have severe and enduring mental illnesses. A large percentage of my clinical practice is based in a low socio-economic area. Consequently, I bulk bill those clients who are on a disability pension or unable to maintain employment due to their mental health/ psychiatric illness.

If the proposal were to go ahead, financially my practice would not be able to provide bulk bill rates. I seriously question where these most vulnerable mental health clients will then receive a service. Certainly not in the public health service which is already under funded and overloaded, to the extent that many of these long tern severe and enduring mental health clients are referred to me by community mental health teams!

Recent correspondence on ATAPS by Northside GP network advises that service agreements with existing providers will only be permitted. They will not be taking on new service providers. Thus, clinically trained psychologists who have expertise in mental health will not currently be able to apply to GP networks to provide ATAPS services to those individuals that the Government has decreed should be seen by this service, i.e., those unable to work due to mental illness and hard to reach groups. This means that the most seriously unwell and psychologically disordered individuals will more often be seen by generalist psychologists who have the least experience and qualifications in mental health but who are also most affordable by GP networks.

Evidence base for the change
The Medicare evaluation on which the Government is making this recommendation is tenuous at best.

The National Committee notes that there are many significant research methodological issues that diminish the credibility of the study. The study did not meet fundamental standards of research design (it did not identify the nature, diagnosis or complexity of the clients seen by psychologists by type of psychologist; it did not identify the nature or type of psychological intervention actually provided; it did not factor in or out medication use by the client; it did not factor in or out therapy adherence indicators; it did not have a valid criterion measure actually related to a range of diagnoses or complexity in order to assess pre and post intervention condition of clients; it did not undertake follow-up assessment of clients, which is

often the point at which the relative strength of any competent treatment becomes manifest; it did not determine relapse rates by type of psychologist; it was a self-selected sample of psychologists who self-selected their clients and clinically administered the research questions in session; it was not subjected to peer review).

Of concern is that Generalist psychologists view this Medicare evaluation as acceptable sound methodological 'research' indicating a noteworthy lack of critical analysis and clinical evaluation, the hallmark of evidence-based practice of a Clinical Psychologist.

Significant concern must be raised if the Government is basing such a major policy change on **one** 'study' alone. A well-designed prospective study aimed clearly at answering specific questions in accordance with principles of psychological research needs to be undertaken before such drastic unfounded policy changes are made.

Recommendations.

Clinical Psychology is the only profession, apart from Psychiatry, whose entire accredited and integrated postgraduate training is specifically in the field of lifespan and advanced evidence-based psychopathology, assessment, diagnosis, case formulation, psychotherapy, evaluation and research across the full range of severity and complexity of mental health disorders.

As a minimum, retain the two tier system. Ideally, divest the two-tier system and implement one rebate at the higher level to Clinical psychologists as those who can most expertly provide mental health services across all 3 levels, as identified by the UK BPS study. Rather than 'dumbing down' the profession of psychology, bringing it up to international standards that are in countries such as the UK, Canada and the USA by ensuring that all those who practice Psychology in mental health are clinically trained. This would ensure consistency among practitioners in training and qualifications and importantly, clients know they will receive treatment by those most expertly qualified professionals. This could be regulated by the APS and Universities as occurs in the UK NHS model.

Maintain the 18 sessions or bring this in to line with psychiatry and permit up to 30 sessions for those with more severe and enduring mental health disorders. This would do away with needing to have two schemes – Medicare and ATAPS.

These Government changes appear a knee jerk cost saving attempt with little long term consideration of the ramifications, for not only and importantly the public who receive this service, but to the profession of psychology as a whole.

Substantial money is likely to be saved by the Government doing away with the lower rebate and having only clinical psychologists provide services (at the current higher rebate level commensurate with their training).