Dear All,

I am writing to express my concerns regarding a number of possible changes to the funding and operation of psychology as a result of the Senate Community Affairs Committee inquiry

My interest in this area is this matter concerns community access to psychological services, particularly for those already disadvantaged or experiencing financial hardship. I am also concerned with the issue of fair pay and appropriate recognition for psychologists. I do not own my own practice and therefore will not be personally affected by many of the proposed changes.

Medicare aims to provide affordable access to healthcare in the community by reimbursing consumers with part of the treatment cost. The purpose of the Better Access initiative is to improve treatment and management of mental illness within the community. These fundamental aims are being challenged by the possible changes that may result from the Senate Community Affairs Committee inquiry.

TERMS OF REFERENCE SECTION e) i
The two-tiered scheduled fee Medicare plan for psychologists

A possible outcome of the Senate Community Affairs Committee inquiry could be a reduction in the rebate provided for clinical psychologists to become the same as that provided for registered (also known as generalist) psychologists.
Psychology is in the category earning a rebate of 85% of the scheduled fee. The Medicare Benefits Schedule Book states:

> "Medicare benefits are based on fees determined for each medical service. The fee is referred to in these notes as the "Schedule fee". The fee for any item listed in the MBS is that which is regarded as being reasonable on average for that service having regard to usual and reasonable variations in the time involved in performing the service on different occasions and to reasonable ranges of complexity and technical difficulty encountered."

This statement makes it clear that the issue ultimately concerns whether registered and clinical psychologists should charge the same schedule fee. There are a number of arguments to be made:

I. As specified by the Australian Psychology Accreditation Council, the training differences between registered and clinical psychologists are immense. Registered psychologists receive four years undergraduate training (including honours) that provides a theoretical basis of psychology. There is only a very basic introduction into assessment and counselling. **Registered psychologists receive no training in treatment of psychological disorders or clinical assessment and treatment**. This also means that they receive **no training the treatments endorsed by the Medicare scheme** (cognitive behavioural therapy, interpersonal therapy, relaxation, psychoeducation and skills training). Clinical psychologists receive an additional 2-3 years of specialist training in an advanced postgraduate degree, specialising primarily in the assessment and treatment of psychological disorders, including those prescribed by Medicare.
   See supplementary information at the end of this document for a more thorough comparison of the training for registered and clinical psychologists
II. The roles of registered and clinical psychologists are profoundly different. As is clear from the differences in training, only clinical psychologists are qualified to practise in the assessment and treatment of psychological disorders. This includes anxiety and depression

as well as more severe disorders such as personality disorders, eating disorders and trauma related disorders.

III. The claim that a registered psychologist should expect the same pay and recognition as a postgraduate trained specialist psychologist is the equivalent of a GP claiming they should be recognised and paid as an Oncologist simply because they also have an undergraduate degree in medicine and experience as a GP. This does not hold in other professions and has no grounding in psychology

IV. If there were no differences in the knowledge and skills between registered and clinical psychologists following training, there would appear to be absolutely no purpose for any postgraduate training. No person would pay more to do further study, foregoing income for several years while completing their degree. The universities too, would be unethical in offering a degree that added nothing to the undergraduate training.

V. Registered and clinical psychologists are paid different rates when employed in most industry roles. It should not be possible (and certainly not equitable) to then apply different rules within the Medicare rebate system. Surely what is regarded as a fee that is "reasonable on average for that service" would be the same when undertaking the same work within a different context.

VI. Research conducted as part of Better Access program evaluation has many significant research methodological issues that diminish the credibility of the study, along with claims of equivalent patient outcomes between different psychologists. The study did not meet fundamental standards of research design. For example, it did not identify the nature, diagnosis or complexity of the clients by type of psychologist (it is likely that clinical psychologists were treating more severely ill clients); it did not identify the nature or type of psychological intervention provided; it did not consider therapy adherence indicators; it did not have a valid criterion measure of diagnoses or complexity to assess the pre and post intervention condition of clients; it did not undertake follow-up assessment (which is often the point at which the relative strength of any effective 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 (psychologist could, and probably would select clients who respond well to treatment); it was not subjected to peer review. With these major research limitations, any differences in the therapeutic outcomes between psychologists cannot be established.

VII. If it were the case that registered and clinical psychologists achieve similar therapeutic outcomes in these circumstances, it does not then follow that the scheduled fee should be equivalent or that clinical psychology as a specialty should not be recognised. This would be similar to suggesting that because GPs and cardiologists can both diagnose and assess heart conditions, both are the same and should be paid the same rate.

VIII. Registered psychologists are not trained in clinical psychology (or any other endorsed area) and presumably, those with no training in an area would also have no skills to practice in such an area

IX. The vast majority empirical research on the effectiveness of psychologists is predominantly from the US and UK where there is no equivalent of a registered psychologist and the minimum standard is specialist training in a particular discipline. It is unclear whether the results of these efficacy trials would also apply to registered psychologists

X. The major psychology organisations in Australia recognise the endorsed areas of practice in clinical psychology (the Australian Psychological Society, the Australian Psychology Accreditation Council, and the Psychology Board of Australia. This would not be the case if there were no differences in the knowledge and skills between registered and clinical psychologists.

XI. In 1989, the Management Advisory Service to the NHS differentiated the health care professions according to skill levels. The group defined three levels of skills as follows:

Level 1- "Basic" Psychology - activities such as establishing, maintaining and supporting relationships; use of simple techniques (relaxation, counselling, stress management).

Level 2 - undertaking circumscribed psychological activities (e.g. behavioural modification).

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.

The group argue that clinical psychologists are the only professionals who operated at all three levels, and "it is the skills required for level 3 activities, entailing flexible and generic knowledge and application of psychology, which distinguishes clinical psychologists..."

The evidence is clear. Registered and clinical psychologists are not equivalent and there is an obligation for the scheduled fee to reflect this. If the fee and associated rebate is reduced for clinical psychologists there are two possible outcomes. Either the consumer will be forced to pay a significant gap, or the clinical psychologists will be paid at a rate far below that which is merited. Neither is just. As disappointing as it is, my guess would be that in many cases, the consumer will be the one who suffers. The client who is in most need, she who suffers from a severe disorder, requiring many sessions provided by a specialised psychologist, is likely to be the one who misses out. Put most simply, this would not be in accordance with the intention of the Better Access initiative.

TERMS OF REFERENCE SECTION b) iv
The quantity of sessions allocated to the consumers of Better Access

There are several reasons why the cuts to number of sessions available for people with mental health problems are a serious concern and frustrate the purposes of Medicare and Better Access.

I. There is a clear relationship between the number of sessions provided and the therapeutic outcome. This is called the dose-response relationship and it has been thoroughly established through empirical research. This relationship has been demonstrated for people suffering from a wide range of psychological problems. The research shows that the number of sessions required for effective treatment in at least 50% of patients is 12-14. Additional sessions beyond this number continue to improve the therapeutic outcome. While there are some people who only require minimal sessions, this research makes it clear that most patients will require a significant number to achieve positive results.

E.g.

Hansen**,** N. B., Lambert**,** M. J. Forman**,** E. M. (2002). The psychotherapy dose-response effect and its implications for treatment delivery services clinical psychology: *Science and Practice, 9,* 3, 329-343

Harnett, Paul; O'Donovan, Analise; Lambert, Michael J. (2010). The dose response relationship in psychotherapy: Implications for social policy. *Clinical Psychologist,14*, 2, p39-44

Wolgast B, Lambert M, Puschner B. (2004). The Dose-Response Relationship at a College Counseling Center. *Journal of College Student Psychotherapy, 18*, 15-29.

II. The average number of 5 sessions, derived from the research for the Better Access program, is likely to be indicative of two things. Firstly, dropout rates are high. An average of 5 sessions is commonly observed in research, and this finding has perplexed researchers due to the number of sessions required to achieve results. Many have explained this as an effect of premature treatment withdrawal due to factors such as ambivalence and poor treatment motivation. Those who are motivated and engaged in treatment will attend the required additional sessions to achieve results. If the quantity of sessions is to be reduced, those who are motivated and most severely affected by mental illness will again be the ones who suffer. Secondly, the fact that many consumers are not using the allocated 12 or 18 sessions is evidence that the allowance of these sessions is not being abused or used inappropriately. Consumers do not appear to be using sessions that they do not require.

Hansen, N. B., Lambert, M. J. Forman, E. M. (2002). The psychotherapy dose-response effect and its implications for treatment delivery services clinical psychology: *Science and Practice, 9,* 3, 329-343

Miller, W.R. & Rollnick, S. (2002). Motivational interviewing : preparing people for change. New York; London: Guilford Press, 2nd ed

III. It is an established ethical obligation for psychologists to cease treatment when further sessions would not further improve the client's psychological condition (Australian Psychological Society Code of Ethics, Section B.11.1). A breach of this obligation can result in a reprimand and continued violations may even result in deregistration. Aside from the typical desire of psychologists to serve their client appropriately, the risk of damage to ones' career is likely to act as a significant deterrent for most psychologists.

IV. Those likely to require extended therapy are those with severe or comorbid psychological problems. Unfortunately, these issues are more common among those who are already socially and economically disadvantaged. If access to the number of Medicare funded psychological sessions is reduced, those who need them most may miss out on the much needed additional sessions.

Again, the evidence could not be clearer. The required number of sessions to achieve clinically significant results for at least half of all clients is 12-14 sessions, with additional sessions producing further improvement. The provision of 12-18 sessions has not been taken advantage of and those who are motivated and engaged in treatment will attend the required number of sessions to achieve results. Psychologists have both a moral and ethical obligation to cease treatment if clients will no longer benefit from therapy. Finally, those most likely to need extended therapy are the already disadvantaged members of the community. This shows that a reduction in the number of sessions available to consumers would fail to be in accordance with the purposes aims of Medicare and Better Access.

Given all of this, I propose that the two the two-tiered scheduled fee Medicare plan for psychologists should remain and that the number of allocated sessions should continue to be 12-18 (or more). Please consider these issues in your decision making process.

Kind Regards,

Katrina Frost
Provisional Psychologist

TERMS OF REFERENCE SECTION e) ii

SUPPLEMENTARY INFORMATION

There is a gross misunderstanding within the community, health organisations and even between psychologists regarding the differences in the training and skills of registered verses clinical psychologists

Information relating to course descriptions in the following section is drawn directly from the Australian Psychology Accreditation Council (APAC) guideline found at the below address: http://www.apac.psychology.org.au/Assets/Files/APAC_Rules_for%20_Accreditation_and_Accreditation_Standards_for%20_Psychology_Courses_Ver_10_June_2010.pdf

Training of Registered Psychologists

Undergraduate

- A three year bachelor degree, with a major in psychology (approximately 8-14 units of study)
- Learning areas must include: scientific discipline of psychology, introductory application of psychology, theoretical positions of psychology, scientific bases of psychology; methods and analyses of the scientific approach, core topics in the theory of psychology such as, abnormal psychology, personality, developmental psychology, perception , *describe* major areas of applied psychology (e.g., clinical, organizational etc)
- **"The emphasis of the course must be on providing an education in the core discipline of psychology and not in one or more specialist areas of the discipline"**

Honours

- One year degree with a research thesis and approximately 4 units of study in psychology
- Learning areas must include: advanced understanding of the core topics in the theory of psychology; construction, implementation, and interpretation of cognitive and personality assessments; knowledge of evidence-based approaches to psychological intervention, understanding the influence of social, historical, professional, and cultural contexts

Post graduation training

- Two years of supervised practice

Training of Clinical Psychologists

Undergraduate and Honours

- The same three year undergraduate degree and honours degree as registered psychologists

Postgraduate Degree

- Two or three years (masters and doctorate respectively) advanced postgraduate study in specialist clinical training with a major research component
- Full coverage and mastery of the general knowledge and skills required by psychological practitioners as well as knowledge and skills in clinical specialisation
- **Learning areas must include:** diagnosis and classification of mental disorders and basic psychopathology; clinical assessment and psychopathology; adult psychological assessment; psychological assessment and treatment of children and adolescents; principles of psychotherapy and basic counselling skills; clinical psychology interventions for severe psychological disorders; health psychology, behavioural medicine and rehabilitation; research methods and evaluation; basic psychopharmacology; ethical, legal and professional matters; general treatment intervention strategies, core behaviour change skills including counselling and cognitive behavioural approaches to helping in group, individual or

organisational settings; research and evaluation; communication and interpersonal relationships

- 1500 hours of supervised practicum plus 500 hours of practicum supervision or, 1000hrs of supervised practicum for masters students
- Standardised higher qualifications of all staff members and a student to staff ratio of 8:1

Post graduation training

- Two years of supervised practice for masters students and one year for doctoral students (although this has been recently introduced)